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THE INSTITUTIONAL CARE OF THE INSANE

IN THE

UNITED STATES AND CANADA

BY

HENRY M. HURD, WILLIAM F. DREWRY, RICHARD DEWEY,

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EDITED BY

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VOLUME I

ILLUSTRATED

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COMMITTEE OF THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION ON A HISTORY OF THE INSTITUTIONAL CARE OF THE INSANE, 1908-1916.

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PREFACE.

The preparation of the "History of the Institutional Care of the Insane," of which this forms the first volume, has been much delayed by an unexpected broadening of the original scope of the work. It was originally undertaken to give in detail histories of every institution in the United States and Canada with special reference to their foundation and development. Early in the course of the work, however, it became evident that such a compilation would not present in a concise and accessible form many important facts which were considered worthy of record for future use, and certain general chapters were added. The extended plan has involved a considerable increase in the labor of compiling the volumes and consequent delay in publication. The change of plan necessitated an extensive correspondence with state boards, state officers, superintendents of institutions, philanthropists and others in every part of the country; and from these various sources valuable information has been obtained which could not otherwise have been gathered.

The thanks of the committee are due to Dr. Spencer L. Dawes, the Commissioner of Immigration; to the New York State Hospital Commission; to Dr. J. Montgomery Mosher; to Mr. T. E. McGarr, formerly Secretary of the Lunacy Commission and later of the State Hospital Commission, all of Albany, N. Y.; to Dr. T. Wood Clarke, of Utica, N. Y.; to the Boards of Control of Minnesota, Illinois, Kansas, Iowa, Kentucky, Ohio, Nebraska, Colorado, Oregon and South Dakota; to Dr. S. E. Smith, of Richmond, Ind., for invaluable assistance in connection with procuring histories of institutions in Indiana; to the State Librarians of Oregon, Washington, New York, Pennsylvania and Maryland for information and access to original documents; to Dr. Frank Woodbury, Secretary of the Pennsylvania Committee in Lunacy; to Dr. C. Eugene Riggs, of St. Paul, for copies of the Minnesota statutes; to the late Dr. H. A. Tomlinson, of St. Peter State Hospital, Minn., for valuable documents; to Dr. F. W. Hatch, of Sacramento, for many histories of the hospitals of

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among the Indians of the Pacific Coast; to Z. T. Wood, Assistant Commissioner R. N. W. Mounted Police, Regina, Sask., Lawrence Fortescue, Comptroller of the Force, Ottawa, Ont., and Dr. A. J. Gillis, Speaker Territorial Council, Dawson City, for information concerning the care of the insane in the Yukon and Northwest Territories; to Dr. C. K. Clarke, formerly Medical Superintendent of Kingston and Toronto Asylums, now Superintendent of the Toronto General Hospital, for sketches of those institutions; to Dr. R. W. Bruce Smith and Edwin R. Rogers, Inspectors of Asylums, for information regarding Ontario institutions; to the late Reuben G. Thwaites, Secretary of the Wisconsin State Historical Society and editor of "The Jesuit Relations," for information as to insanity among the eastern tribes of Indians; to Dr. A. G. Doughty, Dominion Archivist, Ottawa, Ont., and his assistant, Mr. David W. Parker, Mr. Crawford Lindsay, chief English translator for Quebec Legislature, Mr. E. Z. Massicotte, Archivist of the District of Montreal, Miss M. Charlton, Librarian McGill University, and Miss M. L. Meiklejohn, Stanley Institute, Ottawa, Ont., for researches relating to insanity during the period of the French régime in Canada, and copies of documents; to Mr. H. P. Biggar, of Welwyn, England, for researches at the library of the Louvre, Paris, France; to Brother Superior Casimir, for an interesting sketch of the Retraite St. Benoit-Joseph; to Dr. E. Tremblay for a sketch of L'Hospice Baie St. Paul and biographical notices of its founders; to Lady Superioress, Mother M. A. Piché, of the Grey Nunnery, Montreal, for information regarding the early care of the insane in that institution; to James Douglas, LL. D., New York City, and P. B. de Crèvecoeur, Librarian, Fraser Institute, Montreal, thanks are specially due for the loan of rare works relating to the French régime in Canada; to Dr. C. A. Porteous, Assistant Superintendent, Verdun Hospital, Montreal, for invaluable service in the revision of manuscripts and in other ways; to Mr. E. Dyonnet, Secretary Royal Canadian Academy of Arts, for assistance in the translation of old French documents; to Dr. P. H. Bryce, Commissioner of Emigration, Ottawa, Ont., for many courtesies; and to Dr. W. M. English, of Hamilton, for valuable assistance.

The obligations of the committee to the individual superintendents of nearly two hundred institutions in the United States and

Canada are very great; in fact, without their co-operation it would have been impracticable to prepare any adequate history of the movements in the various states and provinces.

It is evident from a careful study of all the material which has come into the hands of the committee that a gradual evolution has occurred in the care of the insane in America during the past half century, which bids fair to change materially the discouraging views as to the hopelessness of their cure which have prevailed for many years in the United States and Canada.

The movement towards the prompt treatment of curable cases without the formality of legal commitment and under the same conditions as in admission to a hospital for general bodily disease, gives every hope that at an early day cases of recent attack may be received everywhere promptly, and that greatly increased numbers can be cured. Cases of a chronic nature are also now much more satisfactorily dealt with in institutions on the cottage plan, with outlying colonies for the employment of patients, and have a correspondingly better opportunity to attain self-support. These movements promise to make material changes in future methods of caring for the insane.

Special personal obligations are due by the Editor to R. G. Hazard, of Peace Dale, R. I., and to C. C. Harrison, of Philadelphia, for generous assistance by loaning books not otherwise obtainable. His thanks are also due to Dysart McMullen, of Baltimore, for invaluable aid in the compilation of histories and the arrangement of material, and to Miss Mary Brinkley, his secretary, who has assisted in the correction of manuscripts and proof-reading.

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PART I

GENERAL HISTORY IN THE UNITED STATES

CHAPTER I

THE ORGANIZED ACTIVITIES OF ALIENISTS

I.

INTRODUCTION.

At the meeting of the American Medico-Psychological Association in Baltimore in 1897, Dr. Theophilus O. Powell, superintendent of the Georgia Sanitarium at Milledgeville, Ga., at that time president of the Association, presented as a presidential address a sketch of psychiatry in the Southern states, which was received with marked attention by all the members present.

In the following year, at the meeting of the Association in St. Louis, a paper was presented from Dr. J. W. Babcock, of Columbia, S. C., who was absent, entitled "A History of the Insane in America, Shall the Association Have one Prepared?" Unfortunately no copy of this paper can be found nor any record of the disposition made of it.

Although no record was made, it is evident that a committee on a history of the Association was appointed, because in the following year in New York Dr. Babcock recommended that the committee appointed the previous year be dropped, and that the whole matter be referred to the Council with power to act. In the discussion which followed appropriate reference was made to the philanthropic work of those who had labored to develop insane hospitals in the different sections of the country, and the consensus of opinion was general that the Council of the Association should take charge of the preparation and publication of an adequate account of their work in behalf of the insane during the previous century and of accompanying biographical sketches of the men who had been concerned in the movement. It was also agreed that the Council should employ an historian to compile whatever material was obtained for such history. These suggestions were adopted and the Council was empowered to employ an historian and to do everything required to advance the work.

The project, however, slumbered until the Cincinnati meeting in 1908, when the matter was again considered and a committee of five was authorized to assume charge of the project and to report at the next meeting of the Association. The president, Dr. Charles P. Bancroft, of Concord, N. H., appointed as such committee,

Henry M. Hurd, chairman, Baltimore, Md.; William F. Drewry, Petersburg, Va.; Richard Dewey, Wauwatosa, Wis.; Charles W. Pilgrim, Poughkeepsie, N. Y.; G. Alder Blumer, Providence, R. I.; and T. J. W. Burgess, Montreal, Canada, to organize the work.

In 1910 at the meeting of the Association in Washington, the first report of the committee was read, and a plan of action was outlined. The Association adopted the plan and appropriated a continuing annual sum of $300 to be used as a publication fund.

In the summer of 1911 a systematic effort was made to interest all members of the Association in the project and to secure from every section of the United States and Canada adequate co-operation in the effort to collect historical material.

The older states like Massachusetts, Rhode Island, Connecticut, New York, Pennsylvania, Virginia and South Carolina were found to have fairly complete records of the earlier institutions. The Hartford Retreat had served as a model for nearly all institutions in New England for patients of the private class. The Worcester State Hospital in Massachusetts, the Utica State Hospital in New York, and the Pennsylvania Hospital for the Insane in Philadelphia had in like manner influenced to a marked degree the erection of similar institutions in all sections of the United States. The Worcester Hospital had many imitators in New England and Canada; while the Utica State Hospital and the Pennsylvania Hospital had been generally copied by new institutions in the South and West; the former for its organization and mode of management, and the latter as furnishing an example of substantial, durable and inexpensive construction.

Several publications were found which gave interesting details respecting some earlier institutions. Among these were the reports of the Worcester State Hospital and of the Brattleboro Retreat, especially the volume known as the "Annals of the Vermont Asylum," prepared by Dr. Joseph Draper on the occasion of the fiftieth anniversary of the founding of the Retreat. The reports of the McLean Asylum, the gathered papers of the New Hampshire State Hospital, at Concord, the history of the Bloomingdale Hospital by Earle and continued by Lyon, J. B. Chapin's portion of Morton's History of the Pennsylvania Hospital, Babcock's History of the Charities of South Carolina, the Report of the Worcester State Hospital for 1828, the Centennial Report of the Williamsburg, Va.,

Hospital, and Burgess' paper before the Royal Society of Canada, were also of great value.

The committee found it difficult to get any adequate or satisfactory account of the condition of the insane in many of the states prior to the establishment of state institutions. The conclusion is forced upon the student of history that the insane as a class at that period were universally neglected, and little or no effort was made to provide anything beyond shelter for them, and sometimes even shelter was lacking. It is also saddening to find that the optimism of the earlier philanthropic movements which culminated in the Hartford Retreat, the Worcester State Hospital, the Brattleboro Retreat, the Utica State Hospital and other kindred institutions was doomed to disappointment. These movements owed their origin largely to the mistaken idea that insanity was a curable disease and that all forms of mental disease, if taken at an early stage, could be quickly cured. Hence the erection of a single institution in states like New York, New Jersey, Pennsylvania, Ohio, Indiana and other Western and Southern states, which soon proved to be wholly inadequate to meet the needs of such rapidly growing commonwealths. Consequently the condition of the insane in these states soon became as bad as before any institution had been built; although unquestionably the erection of institutions improved the standard of public care, and did much to keep before the people the need of increased care and further provision. Whether pioneer states with scanty resources, imperfect means of communication and a general indifference to humanitarian calls could have made more speedy or more liberal provision for the insane, remains a question. All good citizens were struggling for a living and no community had any surplus funds to undertake a work which involved the erection of buildings and the elaborate administrative and professional machinery required for adequate care and proper treatment. For many reasons it has seemed advisable to trace the history of these early pioneer institutions with care and to give comparatively full details as to their organization, hopes, successes and failures.

In each state there arose public-spirited, self-sacrificing, devoted men, who labored faithfully and zealously with scanty resources to develop an interest in the proper care of the insane. In many pioneer states their efforts, however, would have failed had it not

been for the wonderful initiative of Dorothea L. Dix, who year after year visited the newer states to urge the need of better care for the dependent and helpless. The committee accordingly feels that it has been justified in devoting a long chapter to her work, because when viewed after the lapse of more than fifty years it seems more faithful and efficient than that of any other person during the nineteenth century.

The committee early in its work found it prerequisite to successful work to divide the United States and Canada into districts and as far as possible to ask the individual members to be responsible for these districts. Dr. Blumer assumed the responsibility of New England; Dr. Pilgrim, of New York, New Jersey and Pennsylvania; Dr. Dewey of Wisconsin and Illinois; Dr. Drewry of the Southern states; Dr. Burgess undertook the collection of histories from Canada; and the chairman that of the other states in addition to the general editorial work.

The scheme of the enterprise has grown in the hands of the committee. Besides securing historical data covering the early and colonial times, it has been thought wise to trace the evolution of laws of commitment in each of the United States and the provinces of Canada. This has required a large amount of correspondence and investigation. In fact had it not been for the publication by Dr. Salmon, formerly of the Public Health and Marine Hospital Service, now detached for service in connection with the Society of Mental Hygiene, of a compilation of the laws of each state in the Union, it would have been difficult to present a satisfactory abstract of the laws of commitment. The Canadian laws show less diversity, and the task of collecting them has been less onerous.

It also seemed desirable to treat of different methods of care in the various states. This has led the committee to include early care by counties and townships or charitable institutions, prior to any state care. Chapters on county care of the insane have been prepared; also on the care of chronic and acute cases; on the Wisconsin and Pennsylvania systems where institutions have been subsidized by the state; and finally on state care.

Chapters on the administration of hospitals, the immigration problem and the care of the Indian, colored and foreign insane have been inserted.

Under the heading, Treatment of the Insane, considerable pains have been taken to give adequate sketches of the establishment of training schools for nurses in connection with hospitals; the methods of government of hospitals; reforms in methods of caring for the insane; and the development of hospital architecture.

The treatment of the insane by non-medicinal means, such as amusements, industries, etc., and the influence of experimental removals and individual treatment, have been carefully considered.

The long contest which occurred in the Medico-Psychological Association over the so-called "propositions" has received due attention. It is difficult at the present time to conceive why so much feeling was engendered in the discussion which attended the abrogation of the famous "propositions" adopted 20 years before. The chapter is of special interest because it shows how much careful thought was given by men interested in the care of the insane to all questions affecting them and their conscientious desire to do what was right.

There are chapters also on the admission of voluntary patients and the care of the criminal insane.

In the histories of individual states it has been thought advisable to present the states in alphabetical order, and to give with each a careful account of early efforts in behalf of the insane, and the rapid growth of a philanthropic movement for better care from 1840 to 1860. Following general statements in regard to each state, histories are given of institutions for the insane of every character, with an account of their organization, growth and development. These histories include movements which have taken place within states to adopt new systems of treatment, new methods of care, and new methods of governing institutions.

As might be expected, the histories presented by the institutions of different states have varied much. Some have been written with extreme care, others have been hastily put together and present an inadequate picture of the actual condition of the institution. The committee in all such cases has made an effort to procure additional material. It is much to be regretted that it has frequently been difficult to secure many necessary details. In some states, owing to the rapid changes of officers which have followed changes in political control, important details have been lacking, because no adequate records have been kept. In one state it was impossible to

secure the names of the men who had acted as superintendents of an institution; in another, one of the oldest institutions which had an honorable early career was destitute of any details as to its origin or later development. It is hoped that the publication even of these manifestly imperfect histories may in the future stimulate all institutions to keep careful records of the growth and development of their institutions and the name, date of appointment, term of office and period of service of each officer.

Careful efforts have been made to supply adequate biographical details concerning the men who have acted as officers of institutions, or who have been efficient in promoting the welfare of the insane, either as trustees, state officers, or philanthropists. The number of such biographies is upwards of 300, and many more ought to be collected. The committee is aware that these biographies are not uniform in their mode of presentation; many have been taken from biographical notices prepared by friends; a large number from medical journals, and other sources. The biographies of many excellent men are far too brief because fuller details have not been obtainable. It is to be regretted that all could not be treated alike; it has seemed best to supply the essential facts about every man and to give in addition whenever possible the estimate of his character which had been formed by his friends who knew him best.

II.

ASSOCIATION OF MEDICAL SUPERINTENDENTS OF AMERICAN INSTITUTIONS FOR THE INSANE, 1844-1893.

The Association as appears from the records was established in consequence of a casual meeting between Dr. Samuel B. Woodward, of Worcester, Mass., and Dr. F. T. Stribling, of Staunton, Va., both then superintendents of institutions for the insane. As a result of their conversation it was decided to hold the first meeting of the proposed Association on the 16th of October, 1844, at Jones' Hotel in the City of Philadelphia.[1]

On this occasion there were present:

Dr. Samuel B. Woodward, of Worcester State Hospital, Massachusetts.

Dr. Isaac Ray, of the Maine State Hospital for the Insane, Augusta, Me., and subsequently of Butler Hospital, Providence, R. I.

Dr. Luther V. Bell, Superintendent of McLean Asylum at Somerville, Mass.

Dr. Charles H. Stedman, of the Boston Lunatic Asylum.

Dr. John S. Butler, then of the Boston Lunatic Asylum, but later and for 30 years Superintendent of the Hartford Retreat, Connecticut.

Dr. Amariah Brigham, formerly of the Hartford Retreat, but after 1843 Superintendent of the State Lunatic Asylum, Utica, N. Y.

[1] The house in which Dr. K. lived, and which was my home for 27 years, is still interesting not only for its age but for its connection with the formation of our Association. On the 15th of October, 1844, on invitation of Dr. Kirkbride, after some informal correspondence, the "original 13" assembled in the parlor in the evening and formulated some plan of an organization, which was confirmed on the next day, the 16th of October, at a formal meeting held at "Jones' Hotel," which was in Chestnut street above Sixth. This "mansion" is still standing and is the residence of the physician. It is the birth-place of the Association and an interesting specimen of the house architecture of that early period, having been erected prior to the year 1800, and a view of the house with its associations is worthy of preservation.—*Extract from letter of Dr. J. B. Chapin.*

Dr. Pliny Earle, Superintendent of Bloomingdale Asylum, New York City.

Dr. T. S. Kirkbride, Superintendent of the Pennsylvania Hospital, Philadelphia, Pa.

Dr. Wm. M. Awl, Superintendent of the State Hospital at Columbus, Ohio.

Dr. F. T. Stribling, Superintendent of the Western Hospital of Virginia, at Staunton, Va.

Dr. John M. Galt, Superintendent of the Eastern Lunatic Asylum at Williamsburg, Va.

Dr. Nehemiah Cutter, for many years in charge of a private institution at Pepperell, Mass.

Dr. Samuel White, Superintendent of a private institution at Hudson, N. Y.

Of these men, Brigham, Stedman, Ray, Butler and Earle were all natives of Massachusetts; Kirkbride and Awl of Pennsylvania; Woodward and White of Connecticut; Bell and Cutter of New Hampshire; and Stribling and Galt of Virginia. Two of the number, Cutter and White, were in charge of small institutions for private patients, the former in Massachusetts and the latter in New York. Six of them, namely, Woodward, Stribling, Brigham, Ray, Awl and Galt, were in charge of state institutions, while Earle, Kirkbride, Butler and Bell were in charge of endowed incorporated institutions under more or less public control.

Dr. Stedman alone was in charge of a municipal institution, namely, the Boston Lunatic Hospital, which was then under the control of the City of Boston. Several others, however, had gained experience in both corporate and state institutions. Woodward at an early day had been active in the establishment of the Hartford Retreat and had acted as one of its visitors before going to Worcester, while Brigham and Ray had each been connected with state and corporate institutions. Dr. Earle subsequently became superintendent of the State Hospital at Northampton, Mass. Dr. Butler, before becoming superintendent of the Hartford Retreat, had been for three years superintendent of the Boston Lunatic Hospital. They were all men of unusual ability and among the 13 there were at least three groups, each of recognized excellence.

In the planning and construction of buildings and the organization of institutions, Dr. Kirkbride was unquestionably pre-eminent.

DR. WILLIAM McCLAY AWL.

Through his efforts the famous " propositions " governing the construction of buildings for the insane were formulated and brought to the attention of the Association. He also framed the " propositions " which were subsequently adopted as to the organization and government of institutions.

Dr. Ray early turned his attention to medico-legal questions and excelled in the knowledge of law as applied to insanity. He had already written a book upon the " Medical Jurisprudence of Insanity," which had attracted wide attention. He had also written upon insanity and allied subjects. He possessed unusual clearness as a writer and was well grounded in legal principles, many of which were destined later to become formulated into laws.

Ray, Earle, Bell, Brigham, Butler and Galt, all of them in fact, wrote with facility, force and clearness and were well fitted to the task of impressing their ideas upon the medical profession in the United States, though as a purely literary man of wide culture and scholarly aims, it is probable that Dr. Galt took the first place. He had an excellent knowledge of ancient and modern languages; he was reputed to be able to read Arabic, and had also written a work upon the treatment of insanity.

Dr. Brigham had written several small volumes, one on " Influence of Mental Cultivation on Health," another on the " Influence of Religion on the Health and Physical Welfare of Mankind," which had been widely circulated, and a third entitled an " Inquiry Concerning the Diseases and Functions of the Brain, the Spinal Cord and the Nerves."

Those most eminent in the art of medicine were probably Brigham, Bell, Woodward and Earle. In Brigham's early reports occur interesting painstaking and enlightening observations respecting mental diseases. Dr. Earle's literary and professional activity continued for many years, well-nigh to the day of his death. Early in his career he traveled abroad and gave to the *American Journal of Insanity* the results of his observations of foreign institutions. The idea, inherited by the medical profession from Rush, that blood letting was essential to the successful treatment of insanity was opposed by him with great vigor, and it was largely through his efforts that the practice was discontinued. Bell had written upon hygienic and medical subjects, but he will probably be best known to fame by his painstaking and careful observations on a form of acute excitement now known as " Bell's disease."

Dr. Butler was a ready writer and did much to bring a knowledge of the proper and individual treatment of the insane to the notice of those engaged in their treatment. Subsequently, for many years before his death, he was a member of the State Board of Health of Connecticut, to which he contributed valuable papers upon hygienic subjects.

All, with possibly the exception of Dr. Galt, had been trained in the hard school of poverty. They owed their eminence to their own energy, industry and talents and had derived little benefit from wealth or position, though Dr. Bell, it is true, was the son of a man who had been Governor of New Hampshire, then an undeveloped state, as well as Chief Justice and United States Senator. Two of the number, at least, Earle and Kirkbride, were Quakers, and all seemed to have been men of unusually strong religious convictions and belief, as shown by their writings.

It is interesting to notice the comparative youthfulness of most of these men at the time they assumed the care of the insane: Galt was 22; Stribling, 26; Bell, 30; Earle, 31; Kirkbride, 32; Ray, 34; Cutter, 35; Butler, 36; Stedman, 37; Awl, 39; Brigham, 42; Woodward, 45; and White, 53.

Many of them lived to old age, Kirkbride, Stribling, Earle, Ray, Butler, Awl and Cutter more than filling out their allotted three score years and ten, but Galt, Brigham and Bell died comparatively young; Galt in consequence of worry and distress incident to the Civil War; Brigham of grief, over-work and unhygienic conditions in his institution; and Bell of exposure during the Civil War.

It is evident that New England ideas prevailed largely in the organization and management of the different institutions which these men represented, ideas which entailed great economy both in management and construction and induced a certain rigidity of mold which unquestionably hampered their development. It must not be forgotten, however, that the country was then new and most of it was under pioneer conditions, the legal machinery of every state was crude, labor was scarce, markets uncertain, legislatures economical, and every condition of life favorable to thrift and even parsimony.

The original object of the Association was to meet for conference respecting problems which arose in the care of the insane,

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or in the conduct of institutions. The members had little thought of organizing an association for higher medicine or the prosecution of scientific work and, as a consequence, the earlier meetings were largely occupied with the relation of experiences and mutual interchange of opinions. Committees were promptly appointed to report upon matters of practical importance; for example, at the second meeting, Brigham reported on the Moral Treatment of Insanity; Woodward on the Medical Treatment of Insanity; Bell on Restraint and Restraining Apparatus; Awl on the Construction of Hospitals; Butler on the Jurisprudence of Insanity; Kirkbride on the Organization of Hospitals; Earle on the Statistics of Insanity; Brigham on Asylums for Idiots and the Demented; Butler on Chapels and Chaplains; Kirkbride on Post-mortem Examinations; Galt on Asylums for the Colored Insane; Brigham on Proper Provision for Insane Prisoners; and Bell on the Construction of Hospitals for the Insane, a list of subjects which bears witness to the wide field of activities covered by the Association and shows how alive its members were to the practical questions then pressing upon them for consideration.

As all were picked men, no special qualifications or recommendations on the part of future members seem to have been thought necessary to secure admission to the Association; in fact, it was customary for many years to receive as members such men as happened to be appointed superintendents of institutions for the insane throughout the United States and Canada. Eventually, when superintendents of institutions began to be selected according to the political tenets which they held and were more or less constantly changed in order to keep pace with political changes in several doubtful states, the high *morale* and intense feeling of devotion to the interests of the insane, which characterized the Association in its early days, became distinctly lowered and discordant elements crept in. It is interesting to notice, however, that for many years the Association maintained a high standard of efficiency on the part of its members and considered questions which at that time were new and of the utmost practical importance in the development of the public care of the insane. Such subjects as these, for example, were discussed:

"The Treatment of Incurables." "The Relation Between Phrenology and Insanity," phrenology being at this time regarded

as an exact science and its most prominent expounders, Gall and Spurzheim, being considered competent to give correct views as to the classification of insanity. "The Admission of Visitors, Visits to Patients and Correspondence with their Friends." "The Value of Different Kinds of Labor for the Insane." "The Proper Number of Patients in One Institution." "The Utility of Night Attendants and the Propriety of Not Locking Doors of Patients' Rooms During the Night." "The Advantages and Disadvantages of Cottages Adjacent to the Institution." "The Relative Value of Different Kinds of Fuel for Heating the Hospital."

These and many other practical questions were reported upon and discussed with conscientious care by the different members.

As already stated the first meeting of medical superintendents and physicians of hospitals and asylums for the insane convened at Jones' Hotel in Philadelphia, on the 16th of October, 1844, and after a session of two days adjourned to meet in the City of Washington on the second Monday of May, 1846. The title of the Association as agreed upon was "The Association of Medical Superintendents of American Institutions for the Insane," and it was resolved "that the medical superintendents of the various incorporated or other legally constituted institutions for the insane now existing or which may be commenced prior to the next meeting, be and hereby are elected members of this Association." This seems to indicate that the Association was planned to be an organization for consultation and discussion upon matters referring to the conduct of institutions rather than a scientific society for the advancement of psychiatry. Thirteen persons were present.

The second meeting of the Association was held at Coleman's Hotel, in the City of Washington, on the 11th of May, 1846. Dr. Samuel B. Woodward was elected president and Dr. Thomas S. Kirkbride was made secretary. The members in attendance at the previous meeting were largely present, there being only three absentees. One member, Dr. White, had died. Twenty-one members were present, there being several new members.

Reports were received from the various committees appointed at the previous meeting and much discussion was held as to the plans of the Association. A resolution was adopted requesting that autopsies be made in all cases of insanity which had terminated in death, and that the results be reported at the next meeting of the Association.

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It was also decided that each member of the Association be requested to ascertain the facts and circumstances connected with each case of suicide occurring in the state of his residence during the entire year of 1847, and to forward to the chairman of the Committee on Suicide an abstract of the same.

A committee of two was appointed to prepare the transactions of the Association for publication in a collected form, or such parts of the same as it might deem expedient to publish. The secretary was further directed to publish abstracts of the proceedings in the *American Journal of Insanity*, *The American Journal of the Medical Sciences*, and the *New York Journal of Medicine*. The value of publicity seems to have been generally recognized.

The third meeting of the Association was held in the City of New York at the Astor House, on the 8th of May, 1848, under the presidency of Dr. W. M. Awl, of Ohio. Twenty superintendents of institutions were present. Elevations and ground plans of several institutions in the United States and Canada were placed on the walls for examination by members of the Association, and a variety of carving and fancy work done by the patients in the New York State Lunatic Asylum was exhibited. It is interesting to note further that ingenious buckles and other improved features of restraining apparatus were also exhibited. This would seem to indicate that the use of restraining apparatus was not wholly unknown.

Written reports on the following subjects, after a full discussion, were accepted and laid upon the table: By Dr. Rockwell, "On the Comparative Value of the Labor of Patients and the Best Means of Employment in the Winter." By Dr. Kirkbride, "On the Advantages and Disadvantages of Cottages for Wealthy Persons Adjacent to Hospitals for the Insane." By Dr. Bates, "On the Relative Value of Different Kinds of Fuels for Heating Hospitals." By Dr. McFarland, "On the Most Economical Method of Treating the Insane of the Poorer Classes." By Dr. Galt, "On Reading, Recreation and Amusements for the Insane." By Dr. Cutter, "On the Use of Tobacco and Its Effects on the Insane." A paper was also read by Dr. James Macdonald, "On Diseases and Causes of Death Among the Insane." Another by Dr. Earle, "On Statistics of Insanity," and the third by Dr. Stedman, "On the Treatment of Delirium Tremens by Inhalation of Ether."

It is of interest to notice that the members of the Association had the courage of their convictions, and after they had visited and thoroughly examined the asylum on Blackwell's Island, they passed a series of resolutions regarding the treatment of the insane there, from which the following is extracted:

It would be far more grateful to their feelings could they leave this, as they do the other asylums for the insane, in this vicinity, which they have also examined, in silent but respectful regard at seeing great objects properly accomplished. In so doing, they would escape the unpleasant necessity of instituting painful criticisms in the face of personal civilities, and the hazard of being considered, by the unreflecting, as guilty of improper interference in the affairs of a community not their own.

Devoted as most of them have been for many long years of their lives to the care and restoration of those deprived of reason; familiar, as many of them have been from personal examination, with the condition of this class of sufferers under the varying circumstances of the different communities of the old and new world; looking upon themselves while citizens of widely separated states, yet common denizens of that republic of humanity that knows no state lines, they willingly venture all risk of being misunderstood and misrepresented, when they declare their conviction, that the arrangements for the three or four hundred pauper lunatics of this city are far in the rear of the age; of the standard of other regions equally advanced in civilization and refinement; of the imperative demands of common justice, humanity and respect due to the image of a common Father, however much disfigured and changed.

They would, therefore, appeal to the authorities of this mighty and opulent metropolis of the western world, to sustain the honor of their leading position; to those who must feel that they and their children have no immunity against loss of property, of friends, and of reason, to those who recognize the obligations imposed by their own elevation and success to protect the friendless and miserable, to interpose their determined resolution no longer to permit the Empire City to stand below the demands of the age, in the justice, humanity, yea, in the common decency, with which those guilty of no crime, but stricken by the hand of Providence in the loss of reason, are treated. Suffer no longer, we implore you, those whose sensibilities are not extinguished, but may even be more intense, whose honest self-respect and pride of character are not always permanently obliterated, whose return to society and to usefulness is not elsewhere the rare exception, but the expected result; to be abandoned to the tender mercies of thieves and prostitutes, who are, to a considerable extent, the associates and keepers of this helpless charge, and clothed with all the delegated authority and influence which such a relation necessarily implies.

This Association has neither the means nor the disposition to inquire why the pauper lunatics of this community should have been allowed to lapse into that depth of degradation and neglect, of which it would be difficult elsewhere to find a parallel.

Enough is it for them to know, that such is the fact, notwithstanding plans and designs for every modern architectural requirement, as well as curative and ameliorating appliances, have been long in the hands, and subjected to the favorable criticism and comparison of those elsewhere charged with the same duties, and have been recognized as fully adequate to meet the exigency.

They have examined the recent report of the medical visitors, and conclude with them fully in their conclusions, as to the necessity of an entire change in the system, in the impossibility of doing all that justice, humanity and a sound economy require for the insane, except at a cost of money sufficient to provide faithful, competent, respectable assistants or keepers and adequate means of classification, inspection, labor, amusement, ventilation and cleanliness. They believe a just economy requires the abandonment, or conversion to collateral uses merely, of those miserable apologies for insane hospitals, known as the old and the new madhouses; and if the Island is retained as a site for these institutions the original design, fully satisfactory in its great outlines and principles, should at once he carried out to completion.

The superintendents also made the important statement by resolution " that any attempt in any part of this country to select medical superintendents through political bias be deprecated by the Association as a dangerous departure from that sound rule which should govern each appointing power, of seeking the best men irrespective of every other consideration."

The fourth meeting of the Association was held in the City of Utica, N. Y., at Churchill's Hotel, on the 21st of May, 1849. The attendance was not large, less than 20 members being present, several members of the board of managers of the lunatic asylum at Utica were also present, and, for the first time, a superintendent from Canada was in attendance.

Dr. Buttolph, of New Jersey, read a paper on the relation of phrenology to insanty, which elicited considerable discussion and indicated that the majority of the members did not believe that phrenology had a scientific basis.

Dr. Bell, of New Hampshire, read a report " On a Certain Form of Disease Resembling Some Advanced Stages of Mania of the Delirium of Typhoid Fever, or of Cerebral Inflammation, but which may Perhaps Constitute a Hitherto Unrecognized and Undescribed Malady," to which later the name of Bell's disease has been given. The paper apparently did not receive the consideration and discussion which it deserved. It was probably the first original contribution of the Association to psychiatry.

The fifth meeting of the Association was held at the Tremont House, in Boston, on June 18, 1850. There were 28 members present, a portion of whom were members of boards of trustees of institutions for the insane. The most important part of the proceedings was the presentation of a report by Dr. Ray on the project of a law regulating the legal relations of the insane. The report does not seem to have been discussed at this meeting and subsequently was recommitted to a committee to be considered at the next meeting.

Dr. Bell asked in view of a paper which he had read the previous year on a peculiar form of mental disease, now generally known as "Bell's disease," that a committee be appointed to visit a case under treatment at the McLean Hospital and to report the results of their observation. A committee consisting of Drs. Awl, Kirkbride and Fremont, of Beauport Asylum, Quebec, visited the patient and reported later that it was a well-marked case of "Bell's disease," and that "it is frequently met with in large cities where cases manifesting mental disturbance are promptly sent to a hospital for the insane."

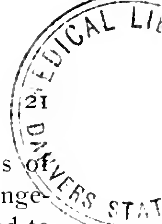
A resolution was passed expressive of the deep interest and unqualified sanction of the Association in the magnificent project at that time being urged on the consideration of Congress by Miss Dorothea Dix, to grant a portion of the public domain for the endowment of public charity throughout the country.

The sixth meeting occurred at Philadelphia, on the 19th of May, 1851. Twenty-two superintendents and trustees were present. Dr. Awl resigned as president and was succeeded by Dr. Luther V. Bell.

A resolution was adopted that the members of the Association report at the next meeting all the fatal cases of Bell's disease and other cases resembling it occurring in their respective institutions, together with the results of autopsies with especial reference to the condition of the brain and the viscera.

A resolution was adopted bearing witness again to the benevolent motives and untiring perseverance of Miss Dix; it recommended the passage of the act by Congress and encouraged her to continue her efforts in behalf of the bill referred to at the last meeting.

DR. JOHN S. BUTLER.



Dr. Kirkbride read a report containing his famous series of "propositions" in reference to the erection and internal arrangement of hospitals for the insane, which will be found referred to at length elsewhere.

The report of Dr. Ray presented at Boston does not seem to have been discussed at this meeting.

The seventh meeting of the Association was held at the Irving House, in the City of New York, May 18, 1852. Twenty-six persons were present.

A resolution was passed requesting the standing committee on the construction of hospitals to present also a series of resolutions embodying similar propositions relating to the direction, organization and management of hospitals for the insane.

A resolution was adopted appointing Dr. Bell to report upon the proper disposition to be made of persons charged with crime and acquitted on the ground of insanity; also upon the care of insane criminals in state prisons, both with reference to the best interests of the insane and the community at large.

The eighth meeting of the Association was held in Baltimore, at the Eutaw House, on the 10th of May, 1853. About 20 persons were present. Much time at this meeting seems to have been spent in excursions, on one of which the almshouse was visited. The members promptly by resolution said that they felt keenly the condition of the insane in almshouses, because in the wards set apart for their care "*there was seen a type of treatment to which this unfortunate class of fellow-beings had been subjected during the darkest period of history*," which indicated that the Association still had the courage of its convictions.

An important paper was presented by Dr. Kirkbride on the night care of the insane. The discussion which followed brought to light considerable difference of opinion. Many concurred in the paper and believed night care to be essential to detect and prevent fire, to effect a proper policing of institutions, and to correct untidy habits on the part of patients by giving them night attention and nursing. It was evident, however, from the discussion that many New England institutions had no night watchmen and that some of the best superintendents did not regard night watching as conducive to the comfort of their patients. It is probable

that each member preferred what he had become accustomed to and may not have had an open mind.

An interesting discussion occurred as to whether typhomania, Bell's exhaustive mania and a form of disease described by Dr. Ray were identical diseases. The general trend of the discussion seemed to establish the accuracy of the original observations of Dr. Bell.

The ninth meeting of the Association was held on May 9, 1854, at the Smithsonian Institution in the City of Washington, D. C. Twenty-two members were present.

Beyond a paper by Dr. Edward Jarvis on the tendency of unbalanced minds to develop insanity, there was little in the way of elaborate articles at this meeting.

In a discussion on treatment, Dr. Curwen deplored too frequent bleeding in cases of excitement.

Dr. Waddell, of New Brunswick, spoke of the use of tartarized antimony as an excellent substitute for bleeding. It is interesting, however, to note that several members expressed their disapprobation of the use of this depressing agent.

Dr. Ray recommended a sustaining treatment and suggested that sometimes his patients required a variety of distilled liquors.

The general impression seemed to be that it was not advisable to use depressing agents in the treatment of acute insanity.

In view of the modern somewhat extravagant exploitation of the continuous bath as a new therapeutic agent in the treatment of acute insanity, it seems proper to mention the fact that Dr. Brown recommended its use for periods of from six to eighteen hours. Several superintendents, however, were opposed to such use of the bath and believed that prolonged immersion did more harm than good.

The tenth meeting of the Association was held in the City of Boston, at the Tremont House, on May 22, 1855. Twenty-six members were present. Dr. Bell retired as president and Dr. Isaac Ray was elected in his place.

Almost the first note of discord in the history of the Association developed over an article published in an issue of the *American Journal of the Medical Sciences,* ascribed to Dr. John M. Galt, of Virginia, in which he spoke of one of the New England institutions being under the control of "one of the most pertinacious tinkers

of gas pipes." There were also other caustic references to the institutions of New England which were unfavorably compared to those in the South. In the course of the discussion Dr. Workman, of Toronto, thought that too much attention had been given to the strictures, presumably, of Dr. Galt. He believed that the asylums for the insane were all still short of perfection, a fact which was abundantly proven by the published reports of the superintendents, in which mention was made of many defects in construction and equipment: if these reports were to be believed, in his opinion, Dr. Galt should not be censured.

An elaborate and highly interesting paper from a literary point of view was presented by Dr. Isaac Ray on the "Insanity of George III."

A paper was read by Dr. Buttolph on the influence of the recumbent position in increasing the vital energies in disease, which seems to have been the first paper upon this subject presented to the Association. The discussion which followed brought out the first reference to what was afterwards known as the crib bedstead. Dr. Gray described the use of the crib bedstead in the hospital, at Utica, and spoke well of it. Drs. Nichols and Buttolph defended its use; upon the whole, although several opposed its use, the opinion of those present seemed to be in its favor.

The eleventh meeting of the Association was held at the Spencer House, Cincinnati, Ohio, May 19, 1856. About 28 members were present.

A paper was presented by Dr. Worthington on a case of prominence of the eye-balls, accompanied by disease of the heart and thyroid glands, which seems to have been one of the earliest papers presented on Basedow's disease in this country.

Dr. Edward Jarvis, of Dorchester, Mass., presented a paper on the care of the criminal insane in which he made a plea for special provision for insane criminals. He believed it to be unwise and improper to leave them in prisons without hope or prospect of recovering their health. They had a claim to treatment and cure and should be sent to hospitals. No man, while insane, could be punished with propriety by confinement in a prison. It was unwise to send insane criminals to hospitals for the insane because their presence disturbed the administration of hospitals and harmed the innocent insane. Criminal patients are as a class cunning and not

trustworthy, and being accustomed to imprisonment they understand how to make their escape, and thus break up discipline and good order, and render it necessary to exercise a strict discipline over all other patients, the greater part of whom otherwise might enjoy a large degree of liberty. The only proper method for the care of insane convicts was to provide special institutions for them, located near to prisons but unlike them, and possessing all the features of a hospital for the acute insane. Insane convicts should be made secure so that they may not escape, and should be under the care of good nurses; occupation should be provided for them. As he believed that no state alone could provide a criminal hospital, he recommended that New England and New York should combine for the purpose and that possibly New Jersey and Eastern Pennsylvania should be included in the same combination. He recommended that Delaware, Maryland, Virginia, the Carolinas, Georgia and Florida should establish another criminal hospital. The Western states should form a district for the third, and the Southwestern states for the fourth. It is evident in the light of our present knowledge that the method proposed was altogether inadequate, as in fact the criminal insane at present require to be cared for in one or more institutions in almost every state. Hospitals in connection with prisons also have not been satisfactory and have generally been abandoned.

The meeting was not well reported, and it is impossible to follow the discussion which is stated in the minutes to have been of unusual interest.

The twelfth meeting of the Association was held at the Metropolitan Hotel, New York, May 19, 1857. Thirty-five persons were present. The principal paper was presented by Dr. John E. Tyler, then of the New Hampshire Asylum, in reference to the care of the violent insane, in which he recommended that violent patients be placed in strong rooms built substantially, but which should be light, cheerful, well ventilated and thoroughly comfortable. In the discussion which followed considerable difference of opinion developed.

Many preferred that violent patients should be cared for in a lodge or detached building, where patients, who were noisy or violent, could be placed at such distance from the other wards as not to interfere with the comfort of quiet patients. The general

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feeling seemed to be against the use of strong rooms, and one or two superintendents expressed a preference for mechanical restraint.

Dr. Ranney presented a paper on the medical treatment of insanity, in which he recommended the use of tartarized antimony and arterial sedatives during the height of excitement, to be followed by morphia and later by tonics. There was nothing especially new in the paper which, nevertheless, gave rise to an extended discussion. The general sentiment seemed to be opposed to the use of tartarized antimony or venesection. Many spoke favorably of the use of opium, hyoscyamus and other anodyne remedies.

The thirteenth meeting of the Association was held at Russel Hotel, Quebec, June 8, 1858. Twenty-four persons were present. Dr. Curwen was appointed secretary. At this meeting the first mention is found of a new form of disease known as general paresis, brought to the attention of the Association by interesting pathological memoranda presented by Dr. Workman. It is of interest to observe the relative frequency of the disease as reported from different sections of the country. Dr. Choate stated that he received from two to five cases of the disease annually but had never seen any case in a woman. Dr. Workman had seen 15 cases, only one of which had been intemperate. Dr. Athon, of Indianapolis, had seen five cases within five years, three being men and two being women. Dr. Green had not seen a case in eight years. Dr. Chipley stated that the disease was rare in the West; he had seen but three cases in three years. Dr. Hills had never seen more than three or four cases in all his experience. Dr. Ray in summing up expressed the opinion that the relation of general paresis to other forms of insanity required to be more thoroughly investigated. He believed it to be impossible to draw a dividing line between general paresis and other forms of disease. It seems probable to the editor that this statement is due to the fact that the diagnosis was confused by the observation of such patients at different stages of the disease.

At this meeting an excellent paper was read by Dr. Isaac Ray on mental hygiene which will prove profitable reading to all persons who have an impression that mental hygiene is a subject but recently brought to the attention of medical men.

The fourteenth meeting of the Association was held at the Phœnix Hotel, Lexington, Ky., May 17, 1859. Seventeen persons were present.

Dr. Ray resigned as president and Dr. Andrew McFarland was elected in his place.

A paper was read by Dr. McIlhenny on various means of restraint. In the discussion which followed all deprecated the use of restraining apparatus, and mentioned modifications which they had made in its application, but no person advocated absolute non-restraint.

A paper was read by Dr. Chipley on what he called sitomania or refusal of food. This paper elicited descriptions of various methods of administering food to patients who declined to eat voluntarily.

The fifteenth meeting of the Association was held at the Continental Hotel, Philadelphia, May 28, 1860. Thirty-four persons were present.

The most important paper was presented by Dr. Jarvis, of Massachusetts, on the proper function of private institutions or homes for the insane. This paper, like all by Dr. Jarvis, suggested a variety of new topics, and was the first one to be read before the Association which had reference to special accommodations for different classes of the insane. In it he spoke of the provision which had been made in England in corporate hospitals, in private institutions, and in county asylums established under the poor law, and contrasted it with what existed in this country, where all classes of patients were sent to public asylums. He believed that the great majority of cases are better provided for in public than in private institutions, and that where patients required special restraint or seclusion, or had suicidal or homicidal impulses, it was better that they should be in public than in private institutions. He considered, however, that the public hospital was more inelastic than the private home, because a larger number of patients required a greater degree of discipline, and a sacrifice in some instances of the interests of the few to the necessities of the many. He thought that a class of patients remained who did not require the close restraint and guardianship of public institutions, and who might be cared for with great comfort to themselves in a private home under the care of a physician. In addition to this he believed that there were

many quiet patients who did not get on well at home and must live away from their friends, who could reside in private families away from home not under the care of physicians.

The paper was not approved by the members of the Association, the majority of whom believed apparently that the public institution was better than the private home. In the remarks made by some of the members a degree of prejudice was manifested towards private institutions as compared with a public hospital, or corporate institutions like the McLean Hospital, the Hartford Retreat, Bloomingdale Asylum and the Pennsylvania Hospital. It is interesting, however, to observe the candid and fair mental attitude of Dr. Jarvis, who in many respects seems to have been in advance of his time.

Dr. Harlow read a paper on inebriety as a disease, which was followed by a discussion eliciting many valuable clinical facts in reference to alcoholic insanity. This seems to have been the first reference in the Association to inebriety as a form of mental disease.

The meeting of the Association for 1861, which was to have been held, was postponed for one year on account of the Civil War, or as the Association stated in its resolutions, "on account of the excited state of the public mind caused by the violent efforts to overthrow the established government."

The sixteenth meeting of the Association was held at the City Hotel, at Providence, R. I., on June 10, 1862. Twenty persons were present, none of them from south of Mason and Dixon's line.

The secretary read a letter from Dr. W. S. Chipley, of the asylum at Lexington, Ky., stating that he was absent from the Association because his attendance was required by the wounded of the Army of the Southwest. Dr. Andrew McFarland also wrote that the late battles in the Southwest and the large number of wounded from his own state made it impossible for him to leave home. Dr. McFarland resigned as president and Dr. T. S. Kirkbride was elected in his place.

The most elaborate paper of the meeting was by Dr. Joseph Workman, of Canada, on latent phthisis in the insane which developed an interesting discussion. In the light of our present knowledge of tuberculosis, it is evident that Dr. Workman had confused a condition which may be developed among the insane by

unhygienic conditions and a possible infection from other tuberculous patients with what he conceived to be the inevitable course of insanity. Feeble patients confined in overcrowded hospitals upon an insufficient diet, we now know, are peculiarly liable to contract tuberculosis. The writer of the paper, however, believed that tuberculosis was a logical and natural termination of insanity.

Dr. Jarvis read a paper mainly derived from his observations of the hospitals and asylums in England in regard to the employment of inmates of institutions in trades. The paper was mainly of interest because it brought out the fact that institutions in this country employed patients in desultory labor in a haphazard way. It seems strange to us at the present time that superintendents of institutions, in the light of the knowledge which they had as to the practice in England, accomplished comparatively little in the way of systematic employment of their patients. It is probably to be explained by the fact that the majority of them were advanced in years, and were no longer equal to the effort of initiating new methods of employment, or of systematic efforts to utilize the labor of patients.

The seventeenth meeting of the Association was held at the Metropolitan Hotel, New York, on May 19, 1863. Twenty-five persons were present. The only member of the Association from the Southern states was Dr. W. S. Chipley, of Lexington, Ky.

This meeting witnessed the first discussion of a question which later occupied much attention in the meetings of the Association, viz.: the existence of so-called moral insanity. The discussion followed a paper from Dr. McFarland on minor mental maladies. It is interesting to see that those who favored the doctrine of moral insanity and were most emphatic in upholding it were Dr. Nichols, of Washington, Dr. Tyler, of Boston, and Dr. Ray, of Providence, all of whom took the ground that the mind, which we now regard as a unit, was really divided into three distinct divisions: the reason, the will and the emotions. Each contended that any one of the three metaphysical divisions of mental action might be a subject of disease without affecting the other. Those who opposed this view were Drs. Chipley, Walker, Gray, Ranney, and Workman, who argued for the physical basis of all mental disease, and believed that whether the mental derangement showed itself in the form of a weakened will or a perverted emotional state, there was also intel-

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lectual disturbance, either in the form of changed mental activity, delusions or other marked mental derangement.

The eighteenth meeting of the Association was held at Willard's Hotel, Washington, D. C., May 10, 1864. There were present 18 persons, of whom two, Dr. W. P. Jones, of Nashville, Tenn., and Dr. John Fonerden, of Baltimore, Md., were from the Southern states.

One of their first acts was to pass a resolution to appoint a committee to wait upon the Surgeon-General of the United States to tender the services of the members to assist in the care of the sick and wounded at Fredericksburg.

One of the most valuable papers presented was by Dr. Gray, of Utica, on a case of pellagra, of which he gave the history. This is the first mention in the proceedings of the Association of this disease. In the discussion which followed it is of interest to learn that Dr. Tyler had seen a case several years before, which at the time he had been unable to classify, but which he now recognized as pellagra. Dr. Earle also called to mind the fact that while in Italy 25 years before he had seen several cases of pellagra in his visit to a hospital for the insane in Milan, and stated that he had made a brief record of these cases in the *American Journal of Medical Sciences* in 1844 under the heading, " Visits to Thirteen Asylums."

Much of the session was taken up with a long discussion upon the best methods of heating and ventilating institutions.

Dr. Ray's project of a law on the legal relations of the insane was presented, and after much discussion it was ordered that the paper proposed by Dr. Ray be printed and circulated among the members of the Association for criticisms which later should be forwarded to Dr. Ray, who had been constituted a committee to make a report upon it at the next meeting of the Association.

Miss Dix was introduced at one session and gave an interesting account of her labors among the sick and wounded in the recent battles.

The nineteenth meeting of the Association was held at the Monongahela House, Pittsburgh, May 13, 1865. Nineteen members were present.

Dr. Chipley read an interesting paper on feigned insanity: its motives and special tests for detecting it, which elicited considerable discussion from the members, and oral reports of many clinical cases.

Dr. Kirkbride read a report on heating and ventilating institutions which reiterated the propositions originally adopted by the Association many years before. The discussion developed the fact that the majority of the institutions were heated by steam and that nearly all were provided with fans for forced ventilation.

Considerable discussion was aroused by a letter from Dr. D. Tilden Brown, questioning the propriety of the appearance of several offensive phrases in the English *Journal of Mental Science,* in a notice of Dr. Ray's sketch of the late Dr. Luther V. Bell, wherein the editor of the *Journal* says: "That Dr. Bell, although feeble in health and with anxious domestic cares, was moved by the demon of war to go forth and aid President Lincoln's hopeless and insane attempt to force on the Southern Confederates the mob-rule of the North by aid of foreign hirelings and ex-attorneys-general."

Dr. Brown further proposed the adoption of a resolution alleging that this statement was regarded by the Association as an unjust aspersion on the character of its former honorable president, and unworthy of the Association of which the *Journal of Mental Science* was the official organ. The resolutions were adopted by a unanimous vote.

The twentieth meeting of the Association was held in Washington, on April 24, 1866. Twenty-seven members were present.

The proceedings were printed with unusual fullness because for the first time all discussions were reported by a stenographer.

The question of moral insanity was brought up again by a paper from Dr. Chipley reviewing the legal decision of a court in Kentucky which announced the recognition of moral insanity as one of the principles of law. This precipitated a long and, as usual, an inconclusive discussion, during which the different members of the Association occupied their respective sides of the controversy with the avowed intention of disposing of the subject for all future time. Nothing new came of the discussion.

A paper presented by Dr. George Cook upon the condition and care of the insane poor in the State of New York was read and gave rise to a prolonged debate.

Two series of resolutions were presented to the Association, the first reading practically as follows:

That each state should make provision for all indigent insane persons within its limits.

That each hospital should be located as near as possible to the center of a given district so that patients may be conveyed to it with as little expense and risk to life as possible.

That it is unwise and inhumane and not economical to attempt to make the labor of the insane pecuniarily remunerative or primarily contributive to their support. That no class of insane except those suffering from chronic and advanced dementia should be cared for outside of a properly constructed, equipped and organized hospital.

And the second series:

That the state should make ample and suitable provision for all its insane.

That no insane person should be treated in any county poorhouse or almshouse in which paupers are maintained and supported.

That a proper classification is an indispensable element for proper treatment and can only be secured in establishments especially constructed for treatment.

That curable and incurable persons should not be cared for in separate establishments.

These propositions were discussed at length by Drs. Gray, Bancroft, Nichols and other prominent men who were generally opposed to the separation of the curable and incurable insane.

Dr. Cook presented, in place of the resolutions committing the Association to a record of its preference for hospital provision for all the insane whether chronic or acute cases, a substitute which provided that the question should be presented in any given state whether or not the chronic insane shall continue to be placed in county poorhouses, or whether provision shall be made for them in institutions built at less cost in connection with existing hospitals for the insane. This resolution received but a single vote, that of Dr. Cook.

Dr. Chipley presented a substitute containing the following propositions which were unanimously adopted:

That each state should make ample and suitable provision for all of its insane.

That insane persons considered curable and those considered incurable should not be provided for in separate institutions.

Dr. Nichols subsequently presented a series of five resolutions which provided:

1. That the large states should be divided into geographical districts so that hospitals could be placed nearly in the center of them and thus be accessible to all persons living within their boundaries and available for treatment.

2. That all state, county and city hospitals shall receive persons in their vicinity, whatever may be the form or nature of their mental disorder.

3. That all hospitals for the insane be constructed, organized and managed according to the propositions of 1851 and 1852.

4. That the facilities for classification or ward separation of each institution shall be equal to the requirements of the several classes of insane received by the institution.

5. And finally, that the enlargement of a state, county or city institution may be properly carried to 600 patients if such be required for the care of the insane.

The first four propositions were unanimously adopted, and the fifth was carried by a vote of eight to six and the resolutions as a whole were adopted by a vote of nine to five.

The twenty-first meeting of the Association was held in Philadelphia on May 21, 1867. Thirty-two persons were present.

The most important communication presented was a paper on "Aphasia," by Dr. H. B. Wilbur of the Hospital for the Feeble-minded at Syracuse, N. Y. It is not known whether this paper was discussed or not.

Beyond the fact that there was much animated and earnest discussion on the care of the chronic insane, few details of the meeting are accessible in the volume of the *American Journal of Insanity*.

The Association decided at this meeting to publish the proceedings hereafter separately in pamphlet form, in view of some dissatisfaction with the comments of the editors of the *American Journal of Insanity* upon the care of the chronic insane.

The twenty-second meeting was held at the American House in Boston, June 2, 1868. Thirty-two members were present.

The principal business of the Association was the discussion and adoption of a project of law for determining the legal relations of the insane.

The Association also adopted a memorial to the Congress of the United States in favor of relieving from political disabilities the superintendents of the hospitals for the insane in the states "lately in rebellion."

The Association visited all the institutions for the insane in Boston, and several general hospitals and other institutions, and received many courtesies from the officers and trustees, and also from the officers of Harvard College.

At the meeting of the Association in New York in May, 1863, a committee had been appointed to examine the whole subject of the legal relations of the insane, and to report the legislation required

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to regulate them. The committee consisted of one from each state, viz.: Drs. Harlow, of Maine; Bancroft, of New Hampshire; Rockwell, of Vermont; Jarvis, of Massachusetts; Ray, of Rhode Island; Butler, of Connecticut; Gray, of New York; Buttolph, of New Jersey; Curwen, of Pennsylvania; Fonerden, of Maryland; Nichols, of the District of Columbia; Gundry, of Ohio; Woodburn, of Indiana; McFarland, of Illinois; Van Deusen, of Michigan; Clement, of Wisconsin; Patterson, of Iowa; Smith, of Missouri; Chipley, of Kentucky; Jones, of Tennessee; and Workman, of Canada and the British Provinces. At the next meeting of the Association, in Washington, May, 1864, the committee presented a report through its chairman, Dr. Ray, which was accompanied by the project of a general law. After considerable discussion, the further consideration of the subject was postponed to the next meeting, but owing to the absence of the chairman, it was not resumed until this meeting in Boston. After thorough discussion and considerable modification the project of law was adopted unanimously.[1]

The twenty-third meeting was held at Staunton, Va., June 15, 1869. Twenty-five members were present.

The following resolution in regard to religious services in institutions for the insane was adopted:

Resolved, That this Association hereby expresses its earnest conviction that religious services of some kind in our institutions for the insane are generally highly salutary to their inmates, and should be regularly held, and that the Association hereby reaffirms the ninth proposition of the series adopted in relation to the organization and management of hospitals for the insane in 1856.

Dr. Nichols presented to the Association a system of statistics adopted at the International Congress of Alienists, held in Paris, 1867, and the papers were referred to a committee consisting of Drs. Jarvis, Nichols and Stribling. Nothing, however, came from this committee.

The twenty-fourth meeting was held at Hartford, Conn., on June 15, 1870. Thirty-nine members were present.

Dr. Kirkbride, who had been president for many years, declined to serve longer and Dr. John S. Butler, of Hartford, was elected president.

[1]See Appendix, page 49.

At this meeting the custom of calling upon the members of the Association from different parts of the United States to give an oral statement of the condition of the institutions in their respective states was inaugurated. This routine practice continued for a number of years and afforded to members an excellent opportunity of learning what had been accomplished throughout the country in the matter of increased provision for the insane.

A paper was read by Dr. Isaac Ray on the prognosis of insanity, which was discussed at great length without reaching any special conclusion.

Dr. Barstow presented a paper on the systematic instruction of patients, which elicited discussion. It may be remembered that Dr. Brigham, of the State Asylum, at Utica, inaugurated such systematic instruction many years before.

Dr. Ranney said that in the Iowa State Hospital, systematic school exercises had been introduced during the past two years. There had been also systematic teaching at the McLean Asylum and at the Eastern Asylum at Williamsburg, Va. Several members present, however, opposed the introduction of school instruction unless the work could be done in such a way as to relieve the ordinary monotony of a school. Many preferred light gymnastics, military drills, or light employment calculated to occupy the attention of the individual without tiring him.

A discussion arose later upon the use of hypnotics, especially of chloral hydrate, which was beginning to be used extensively in hospitals to produce sleep.

The twenty-fifth meeting of the Association was held at Toronto, Canada, June 6, 1871, under the presidency of Dr. John S. Butler, of Hartford. Thirty-seven members of the Association were present and six additional persons by invitation.

For some years previous there had been much discussion as to the advisability of uniting the Association with the American Medical Association. Dr. Curwen, who had been appointed a delegate to attend the San Francisco meeting of the latter association, reported that after due consideration it had been agreed on the part of both Associations that such a union was not wise. The report was accordingly accepted.

A long discussion then occurred upon the fruitful theme of many previous meetings, namely, the proper size to which existing

institutions might be enlarged. A resolution was finally adopted permitting an increase to 600 patients as a maximum. This seems to have been the last time an attempt was made in the Association to prescribe what the size of any institution should be. The resolution was adopted by a majority vote.

Dr. H. B. Wilbur, of Syracuse, presented a paper on moral insanity, which, as usual, gave rise to an animated discussion with no harmonious conclusions.

Dr. Joseph Workman, of Toronto, presented an interesting paper from a historical standpoint on demonomania and witchcraft, which, as an interesting example of historical research, elicited an animated discussion.

The commission on statistical tables presented forms of tables, 21 in number, covering the statistics which were deemed desirable in connection with the Association. These tables were used for some years but were never generally adopted and passed out of general use at the time when commissions in lunacy in the different states prescribed special tables for their statistics. They were largely adapted from English tables, and as they did not grow out of the needs of institutions in this country, they had little value.

Resolutions were adopted commending didactic and clinical instruction upon insanity in connection with the medical schools of the country, which was the first official recognition of the necessity of giving better instruction in psychiatry to medical men.

Probably the most interesting paper of the meeting was presented by Dr. Jarvis, of Massachusetts, on the cottage system for the care of the insane. The discussion developed much difference of opinion as to the advisability of erecting cottages, but it was evident from the opinions expressed that the movement had gained the approval of a large number of the members of the Association.

The twenty-sixth meeting of the Association was held at Madison, Wis., May 28, 1872. Forty-one members were present. Dr. J. S. Butler was president.

A paper was presented by Dr. Curwen on the diagnosis and treatment of insanity, which once more brought prominently before the Association the doctrine of moral insanity. In the discussion of the paper a brave member, who had apparently not attended previous meetings, ventured to inquire whether or not the Association recognized the existence of moral insanity, which again brought up the subject for renewed and ineffectual discussion.

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Dr. Gray read a paper on the causes of insanity, in which he formulated his views as to the physical basis of all mental disease. He also gave some account of his pathological studies.

A large portion of a long session was spent in oral reports from members of the Association as to what was being done for the insane in their own states. The reports given by the majority were disheartening, because they showed that nearly every state was far behind its needs in adequate provision for the insane.

An interesting paper was read by Dr. Isaac Ray on the criminal law in regard to insanity, which was followed by a long discussion.

A series of resolutions were presented and unanimously adopted, protesting against admitting a greater number of patients to any institution than its buildings could properly accommodate.

Dr. Ranney, of Iowa, gave an account of the recent legislation in that state to secure a closer inspection of institutions for the insane. A commission, comprising a lawyer, a physician and a lady, was required to visit hospitals monthly or oftener, and had power to discharge any person employed in the institution who in its opinion merited discharge. The commission was also required to see that all letters written by patients were sent to their friends. He reported that as a medical officer of the institution at Mt. Pleasant he had complied with the new law conscientiously, but that the legislation had caused great difficulties in maintaining discipline in his institution.

The twenty-seventh meeting of the Association was held at the Eutaw House, Baltimore, May 27, 1873. Fifty-two members were present. The first day of the session was largely occupied in receiving reports from the different states.

Dr. John S. Butler presented his resignation as president and Dr. Charles H. Nichols, of Washington, D. C., was elected to fill his place.

Dr. Gray read a paper on the pathology of insanity, which elicited some discussion, but it was evident that neither Dr. Gray nor the members who discussed the paper had much definite knowledge of the subject. The paper is to be commended as one of the early attempts at purely scientific work.

The twenty-eighth meeting of the Association was held at Nashville, Tenn., May 19, 1874. The vice-president, Dr. C. A. Walker, occupied the chair. Thirty-five members were present.

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The first day's session was occupied in the presentation of reports from the different institutions of the country. These reports indicated that a general effort was making or had been made in nearly every state to erect new institutions or to increase the capacity of institutions already existing in order to accommodate the rapidly increasing number of insane patients. The general outlook seemed to be encouraging.

A paper was presented by Dr. Ranney, of Iowa, in reference to the working of a law in that state entitled: "An Act to Protect the Insane." It was in effect a defense of the use of mechanical restraint. The covered bed was, in the opinion of the writer, as comfortable as an ordinary bed and most useful in the case of suicidal patients. He believed that the covered bed afforded a full equivalent for watching or other supervision and was not liable to interfere with sleep.

In the discussion which followed there was a general agreement that his views were correct, and they were generally endorsed.

The acting president of the Association in concluding the discussion deprecated laudations of restraint, but expressed the belief that the amount of restraint in this country had been reduced to a minimum. He made the statement also that in his experience in English institutions considerable complaint had been heard from the medical officers because they were prohibited from using mechanical restraint.

During the session a lengthy and inconclusive discussion occurred upon the use of chloral hydrate and other hypnotics. It is evident from the remarks of the members that hypnotic remedies at that time were generally used in many institutions throughout the country.

The meeting had many interesting social features, but no paper of moment was presented.

The twenty-ninth meeting of the Association was held at Auburn, N. Y., May 18, 1875. Forty-nine members were present, and 13 other persons by invitation. Dr. Charles H. Nichols was president.

The first day's session was largely occupied in receiving reports from the different states.

Dr. Gray read a paper on the pathological changes in the brain detected by the microscope with illustrations of disease by means

of a stereopticon. This was the first pathological paper presented to the Association in this manner.

Dr. J. C. Bucknill, of England, was a visiting delegate to the Association and participated in the discussions.

The Association passed a series of resolutions that it is the duty of each one of the United States and each one of the provinces of the Dominion of Canada to establish proper institutions for the care of inebriates, to which patients can be committed and there detained against their wills until such time as they are able to exercise self-control in the matter of the use of alcoholics. The meeting seems to have been barren of any elaborate papers or practical action, although there were extensive and interesting discussions upon a variety of topics relating to the insane.

The thirtieth meeting of the Association was held in Philadelphia, June 13, 1876. Fifty-six members were present, and about 20 other persons by invitation.

Reports were received from the different states in more or less detail respecting actual provision for the insane. Members gave interesting reports from Maine, Rhode Island, New York, New Jersey, Pennsylvania, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Mississippi, Texas, Tennessee, Louisiana, Ohio, Illinois, Indiana, Wisconsin, Iowa, Missouri, Minnesota, Massachusetts and the District of Columbia; from New Brunswick and Ontario. These reports were limited to what had already been done and no time was devoted to the consideration of future plans.

In each state there were complaints of overcrowded institutions and insufficient provision for the immediate needs of patients. Many new institutions were in process of erection and many older institutions were being enlarged to satisfy the need of further accommodation.

Two papers were presented on a comparatively new subject. Dr. Denny, of Hartford, Conn., spoke of the newer methods of pathological investigation and Dr. Gray, of the Utica State Hospital, gave an account of the pathological studies which had been made at his institution. Many of the results of such investigations were vague, and in the light of our present knowledge somewhat misleading. The papers, however, indicated that the minds of the members were turned towards increased scientific work.

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Dr. Ray presented a paper on the criminal responsibility of the insane which was discussed by many members. During the discussion the New York law of 1874, to determine the presence of insanity in criminal cases, was highly commended. By the provisions of this law it was possible to secure the examination of persons indicted for crime, in whose behalf insanity had been pleaded as a bar to conviction, prior to a trial. The law gave the governor of the state the right to appoint three experts to investigate the condition of the patient and to report to him prior to his action. During the discussion the weakness of the hypothetical question which had given unusual preponderance to the evidence of so-called experts was dwelt upon by several speakers.

A discussion also took place in regard to the law in Maine, under the provisions of which it was possible to commit a person accused of crime and who gave evidences of insanity to an institution for the insane for observation prior to trial.

An interesting feature of the proceedings was a statement made by Dr. Ray and Dr. Kirkbride, both residents of Philadelphia, as to the lamentable conditions of insane persons in the Blockley Almshouse.

Another paper worthy of consideration was presented by Dr. Baldwin, of Virginia, on furloughing patients. The sentiment of the Association seemed to be in favor of the experimental removal of incurable patients, and the suggestions of Dr. Baldwin were generally approved.

The thirty-first meeting of the Association was held at St. Louis, at the Lindell Hotel, May 29, 1877. Dr. Nichols was president. Forty members of the Association were present, and six others, mainly trustees of institutions or secretaries of boards of charities, were present by invitation.

The call of states for reports on the condition of the insane and the progress made occupied the first day. Reports were received by members from Ohio, Rhode Island, New York, New Jersey, Pennsylvania, West Virginia, North Carolina, Mississippi, Texas, Kentucky, Indiana, Illinois, Wisconsin, Missouri, and from the Province of Ontario in Canada.

In the report from Illinois, the first reference was made to Dr. Wines' plan of building a hospital in Illinois on what was termed the village plan, or in other words, after the model of a small town,

a plan which was afterwards carried into effect at Kankakee, Ill., at Toledo, Ohio, and at Craig Colony in New York.

A unique incident of the meeting was the celebration of the ceremony of marriage between Dr. Andrew McFarland, a former president, and Miss King, in the presence of the whole Association.

The much worn subject of mechanical restraint of the insane was presented by Dr. Grissom, of North Carolina, in a paper entitled: " Mechanical Protection of the Insane." This was largely an indictment of the methods of non-restraint in England, and an attempt on the part of the author to show that non-restraint there had worked badly and had not benefited the insane. The paper was discussed at great length, and well-nigh every member seemed to favor the extreme statements made therein except Dr. Gundry, of Ohio, who pointed out the evils of restraint. It is evident that a preponderant sentiment in favor of mechanical restraint existed among the members, more especially among those who had lately come into the service. It is interesting to note that one of the advocates of restraint was Dr. R. M. Bucke, of Ontario, who later in his career became a strenuous advocate of non-restraint methods.

Dr. Bucke read a paper on the " Functions of the Great Sympathetic," which was later developed into a book entitled " Man's Moral Nature."

Dr. Gray read a paper on " Suicide."

The thirty-second meeting of the Association was held at Willard's Hotel, in the City of Washington, May 14, 1878. Dr. Nichols was president. Forty-nine members were present, and four others, members of boards of trustees, were present by invitation.

An attempt was made to dispense with further reports on the conditions of the insane and provision existing for them in the different states, but the effort proved unavailing, and much of the session was taken up in considering them. Reports were presented from Massachusetts, Connecticut, New York, New Jersey, Pennsylvania, Maryland, Virginia, West Virginia, Mississippi, Tennessee, Kentucky, Texas, Louisiana, Missouri, Iowa, Wisconsin, Michigan, Ohio, North Carolina, Indiana, and the District of Columbia; also from the Province of Ontario.

It is evident that although these reports furnished nothing new to science they were of service because they gave a fuller knowledge of what was attempted throughout the United States.

The report of a so-called case of kleptomania presented by Dr. Eastman, of Massachusetts, gave rise to an interesting discussion and furnished an occasion for a renewed difference of opinion upon the question of moral insanity.

Dr. Wallace, of Texas, read a paper on the construction of hospitals in which he criticized the excessive cost of many hospitals and presented his own views as to the character of the buildings which he favored.

Considerable feeling was displayed by some of the members who discussed the paper and who deemed it unfair to compare the cost of buildings in a state possessing, throughout the year, the mild climate of Texas, with that of institutions situated in the severer climate of Canada or New England.

The thirty-third meeting of the Association was held in Providence, R. I., at the Narragansett House, June 10, 1879, under the presidency of Dr. Nichols. Forty-seven members were present, and also several members of boards of trustees by invitation.

Dr. Nichols, who had held the position of president for a number of years, presented his resignation and Dr. C. A. Walker, of Boston, was elected to succeed him.

The presentation of reports from the different states was omitted by unanimous consent and the sessions were largely occupied with the reading and discussion of papers.

It is noteworthy that a paper was presented by Dr. Kirkbride which gave clinical notes of three cases under treatment in his own institution with autopsy findings. Dr. Kempster, of Wisconsin, also presented a series of pathological findings in connection with cases which had been under his care.

Dr. Ray presented a paper on the curability of insanity, which elicited an earnest but inconclusive discussion.

Dr. Shew, of Connecticut, read an interesting paper on a visit to Gheel; Dr. Draper, of Vermont, on the responsibility of the insane while in hospitals.

The thirty-fourth meeting of the Association was held at the Continental Hotel, at Philadelphia, May 25, 1880. Dr. C. A. Walker was president. Forty-nine members were present, and many other persons by invitation.

An interesting paper was presented by Dr. C. F. MacDonald on feigned epilepsy, which gave rise to an interesting discussion and a report of a large number of similar cases.

Dr. J. B. Chapin read a paper on experts and expert testimony, which was followed by a long discussion. All members favored a change in the law but none seemed to be able to suggest what should be done, there being no unanimity of opinion.

The thirty-fifth meeting of the Association was held at Toronto, June 14, 1881. Dr. J. H. Callender, vice-president, was in the chair in the absence of the president, Dr. Walker. Forty members were present, and a large number of other medical men and trustees of institutions were present by invitation.

The death of Dr. Isaac Ray was announced and a full bibliography of his writings was presented in connection with a memorial notice prepared by Dr. Kirkbride.

A paper on separate institutions for different classes of the insane was presented by Dr. Gundry, which was discussed at length. Considerable difference of opinion was developed among the members as to the advisability of providing separate institutions for different classes of the insane. The majority were of the opinion that it was better to gather all classes into one institution.

The thirty-sixth meeting of the Association was held at the Grand Hotel, Cincinnati, May 30, 1882. Dr. Walker resigned the presidency and Dr. Callender was elected in his place. Forty-one members were present.

It was decided to change the tenure of office of the president and vice-president of the Association so that in future they might be elected annually.

It was also decided to reorganize the work of the Association into eight committees in order to give a fuller account of progress in the various branches of psychiatry. Committees were appointed as follows:

1. Annual Necrology of the Association.
2. Cerebro-Spinal Physiology.
3. Cerebro-Spinal Pathology.
4. Therapeutics of Insanity.
5. Bibliography of Insanity.
6. Relation of Eccentric Diseases to Insanity.
7. Asylum Location, Construction and Sanitation.
8. Criminal Responsibility of the Insane.

It may be noticed here that while the object sought to be obtained was undoubtedly commendable, the division of responsibility im-

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plied by committee work destroyed initiative on the part of individual members, and the scheme proved to be a failure and was soon given up.

A paper was presented by Dr. R. M. Bucke, of Canada, entitled: "The Growth of the Intellect," which was an attempt to show how the human mind had developed at the different ages of the world.

A paper was read by Dr. Richard Dewey on the differentiation and segregation of certain classes of the insane, in which he recommended separate provisions for the epileptic and criminal insane, also separate buildings for the chronic insane who no longer required the care and treatment usually given in the ordinary hospital buildings. The discussion developed a wide difference on the part of the members and there was no consensus of opinion.

The thirty-seventh meeting of the Association was held at Newport, R. I., June 26, 1883, under the presidency of Dr. John P. Gray. Forty-three members were present, and a large number of invited guests.

A report was read from the Committee on Cerebro-Spinal Pathology by the chairman, Dr. Daniel Clark, of Toronto.

The Committee on the Therapeutics of Insanity reported through Dr. R. H. Gale principally upon the newer hypnotics.

Dr. Joseph G. Rogers read a paper on the Therapeutics of Insanity.

A report was also presented on the Bibliography of Insanity.

The report of the Committee on The Criminal Responsibility of the Insane was presented by Dr. Everts and gave rise to a lengthy discussion.

The thirty-eighth meeting of the Association was held at Philadelphia, May 13, 1884. Dr. John P. Gray was president. Fifty members were present, and a large number of trustees, managers and others by invitation.

The early sessions were occupied by tributes to Dr. Thomas S. Kirkbride, one of the oldest members of the Association, who had recently died.

An interesting paper on the Therapeutics of Insanity and New Remedies was read by Dr. Andrews.

One of the most important matters considered was presented by Dr. Foster Pratt, of Michigan, on the great increase of insanity in the United States, due to the unrestricted immigration of for-

eigners. In forcible resolutions which were unanimously adopted a plea was made that Congress should give immediate attention to the enactment of an immigration law to prevent the admission of insane and defective persons from Europe and Asia. This was one of the first steps taken by any public body to call the attention of the government to the great burden which the foreign insane had brought upon almost every state in the Union.

In the discussion of a paper which had been presented on the subject of cheaper buildings for the insane, reference was made by Dr. Channing to the proposal recently made in Massachusetts to adopt what is termed mill construction, which is economical, not costing over $150 per capita, and for essential purposes is fireproof.

During the sessions a resolution was submitted allowing assistant physicians in state and corporate institutions to become associate members of the Association after five years of continuous service in their hospitals.

The thirty-ninth meeting of the Association was held at Saratoga, June 16, 1885. Dr. Pliny Earle was president. Fifty-nine members were present, and many others by invitation.

A report was read from Dr. Daniel Clark, as chairman of the Committee on Cerebro-Spinal Pathology.

Dr. Andrews read a report from the Committee on Therapeutics of Insanity and New Remedies, in which he spoke of the therapeutic use of tea, especially a fluid extract which had been made by Dr. Squibb.

In a report presented on the resolution adopted to open the doors of membership in the Association to assistant physicians, some interesting facts were brought out. Replies had been received to personal letters from 84 of the 94 public institutions in the United States. In these 84 institutions 208 assistant physicians were on duty; 35 of them had been in service longer than one year; 38 from one to two years; 28 from two to three years; 20 from three to four years; 15 from four to five years; 14 from five to six years; 16 from six to seven years; 13 from seven to eight years; seven from eight to nine years; four from nine to ten years; five from 10 to 11 years; three from 11 to 12 years; one from 14 to 15 years; three from 15 to 16 years; one from 16 to 17 years; one from 19 to 20 years; two from 20 to 21 years; and one for 28 years. To sum up, 73 assistants had served more than five years. As a result of this

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report a resolution was adopted that five years' continuous service as an assistant medical officer should entitle him to membership in the Association as long as he shall continue a medical officer.

An effort was made to change the name of the Association to the following: "The Association of Medical Superintendents and Physicians of American Institutions for the Insane," but the resolution was lost.

A resolution was adopted that all assistant physicians connected with regularly constituted institutions for the insane be made ex-officio members of the Association.

The fortieth meeting of the Association was held at Lexington, Ky., May 18, 1886. Dr. Orpheus Everts, of Ohio, was president, and 39 members were present.

The number of formal papers presented was comparatively small and the proceedings were largely employed in discussions of certain vital questions.

Dr. W. D. Granger, of the Buffalo State Hospital, read an important paper on training schools for nurses in hospitals for the insane, which gave an account of the first training school in a state hospital, that at Buffalo, New York. In the discussion which followed interesting facts were elicited in reference to the first training school for nurses, which had been established at the McLean Hospital in Massachusetts, a department of the Massachusetts General Hospital.

There was also an animated discussion on open doors in institutions for the insane, which brought out the interesting fact that many institutions had one or more wards with open doors for the better care of quiet patients.

Dr. Foster Pratt presented interesting statistics respecting the increase of insanity by reason of pauper immigration from European and Asiatic countries.

The forty-first meeting of the Association was held at Detroit, June 14, 1887. Dr. H. A. Buttolph, of New Jersey, was president. Fifty-four members were present, and a number of physicians, trustees and others by invitation.

The meeting was mainly memorable because of the increased number of scientific papers presented and the discussions which followed.

Dr. C. K. Clarke, of Canada, gave a paper on goitre and insanity which seemed to indicate that in certain sections of Ontario goiter prevailed among the residents to a much greater extent than the general average throughout Canada.

Dr. W. L. Worcester read a paper with illustrative cases on localization of cerebral functions, which was one of the first on this subject to be presented to the Association.

Dr. Cowles, of the McLean Hospital, read a paper on nursing reform for the insane, which gave full details of the methods employed in the instruction of nurses and the results obtained in the way of note-taking and history writing.

The forty-second meeting of the Association was held at Fortress Monroe, May 15, 1888. Dr. John B. Chapin, of Pennsylvania, presided. Fifty-four members were present, and ten persons by invitation.

A paper was read by Dr. Talcott on "Traumatic Insanity and Traumatic Recoveries," which elicited an interesting discussion.

Dr. Steeves, of St. John, N. B., presented a paper on the "Relations of Tuberculosis to Insanity," which brought out the fact that no special relation existed between tuberculosis and insanity. The number of patients in institutions dying from tuberculosis was found to be about the same as the proportion of tuberculous patients in general communities. The author believed that there was no necessary connection between tuberculosis and the development of insanity. If tuberculosis existed in the case of a patient in an institution there was reason to think that the circumstances of the institution were such as to favor an infection from some other patient or to lower his vitality so that tuberculosis might develop.

Dr. Richardson, of Ohio, presented a paper on the practical working of the associate dining-rooms, which was one of the first accounts given of this manner of providing dining-room accommodations for patients in the United States.

A large part of the sessions of two days was taken up with a discussion of a report upon the modification of the "propositions," a fuller account of which may be found in a later chapter on the "propositions."

The forty-third meeting of the Association was held at Newport, June 18, 1889. Dr. W. W. Godding, of Washington, was

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president. Forty-seven members were present, and 10 persons by invitation.

A paper was presented by Dr. Preston, of Virginia, on the "Moral and Curative Effects of Associate Dining Rooms." This paper brought out the fact that associate dining-rooms were already in use at St. John, N. B., at Norristown, Pa., at Harrisburg, Pa., and in Ohio.

Dr. Stedman presented a paper on the family system of provision for the insane. In the discussion which followed considerable difference of opinion was developed as to the utility of family care.

Dr. A. R. Moulton, the secretary of the Massachusetts Board of Insanity, presented interesting statistics which showed the great advantage of such care to selected patients. He stated that 113 patients were boarded out in Massachusetts and that their condition was more comfortable than had been the case in an institution.

Dr. Cowles presented an interesting paper on the mechanism of insanity, which elicited a valuable discussion on physical training.

The forty-fourth meeting of the Association was held at Niagara Falls, June 10, 1890. Dr. H. P. Stearns, of Connecticut, was president. Sixty-six members were present, and 18 other persons by invitation.

In obedience to the general sentiment of the Association no excursions or outside engagements had been arranged for, and the whole time was devoted to the serious work of the regular sessions.

A paper was presented by Dr. Charles W. Page on the "Relation of Attention to Hypnotic Phenomena." It may be remembered that at this time much popular interest had been excited by the observations in France as to the benefits of hypnotism in the treatment of various morbid mental conditions.

Dr. Carlos F. MacDonald read a paper on recent legislation for the insane in the State of New York, which occasioned a discussion upon methods of admission to institutions and also upon the government and administration of institutions.

Dr. Wey presented a paper on physical training as a means of mental improvement, which brought out many instructive facts as to the practice in different institutions for the insane.

A resolution was adopted expressing the gratification of the members of the Association that the State of New York had passed a law to provide state care for all of her dependent insane. It was

further added, as the opinion of the Association, that the principle that the insane are the wards of the state should be universally recognized and members should labor earnestly for the adoption of similar legislation throughout the country.

An exciting discussion occurred upon politics in asylums, but no action was taken. One member of the Association announced that he was in favor of the political control of institutions; otherwise, the sentiment seemed to be unanimously against it.

A lengthy discussion also occurred upon the topic "Are Hospitals for the Acute Insane only Desirable?" The sentiment seemed to be in favor of the present large hospitals with different departments for different classes.

Dr. Cowles read a paper upon training schools for nurses among the insane, which gave valuable information as to the method of organizing such schools.

A report was received from a committee appointed at a previous meeting in reference to the publication of a manual of post-mortem examinations for the use of institutions. Dr. Blackburn, of the Government Hospital for the Insane, was asked to prepare such a manual and the secretary was instructed to make a contract for printing the same.

The forty-fifth meeting of the Association was held at Washington, May 28, 1891. Dr. Daniel Clark, of Ontario, was president. Ninety-two members were present.

The most important subject for consideration at this meeting of the Association was the reorganization of its work in order to secure a more compact and efficient organization. The general sentiment seemed to be that instead of being an association of superintendents of institutions for the insane, it should become an association for the treatment of the insane and the study of insanity. A resolution was adopted appointing a committee of 13 members to revise and expand the constitution and by-laws and to formulate a plan to be considered and adopted at the next meeting of the Association.

The forty-sixth meeting of the Association was also held in Washington, on May 3, 1892. Dr. J. B. Andrews was president. Seventy-two members were present, and a large number of visitors by invitation.

A discussion occurred on the surgical treatment of insanity, epilepsy and other nervous diseases which was participated in by many members and a large number of specialists.

Professor Donaldson, of Clark University, presented an interesting paper on the results of the study of the brain of the well-known Laura Bridgeman, who was blind, deaf and dumb and nearly destitute of the sense of smell and taste.

The Committee on Reorganization presented a plan of reorganization, together with a constitution and by-laws, which was carefully considered and adopted. It provided for a board of counsellors, for active, associate and honorary members, and also arranged for the publication of a volume of transactions.

APPENDIX.

Project of the Law Adopted by the Association in 1868.

Preamble.—The Association of Medical Superintendents of American Institutions for the Insane, believing that certain relations of the insane should be regulated by statutory enactments calculated to secure their rights and also the rights of those entrusted with their care, or connected with them by ties of relation, or friendship, as well as to promote the ends of justice, and enforce the claims of an enlightened humanity, for this purpose recommend that the following legal provisions be adopted by every state whose existing laws do not, already, satisfactorily provide for these great ends:

1. Insane persons may be placed in a hospital for the insane by their legal guardians, or by their relatives, or friends, in case they have no guardians; but never without the certificate of one or more reputable physicians, after a personal examination, made within one week of the date thereof; and this certificate to be duly acknowledged before some magistrate, or judicial officer, who shall certify to the genuineness of the signature, and to the respectability of the signer.

2. Insane persons may be placed in a hospital, or other suitable place of detention, by order of a magistrate, who, after proper inquisition, shall find that such persons are at large, and dangerous to themselves or others, or require hospital care and treatment, while the fact of their insanity shall be certified by one or more reputable physicians, as specified in the preceding section.

3. Insane persons may be placed in a hospital, by order of any high judicial officer, after the following course of proceedings, viz.: On statement in writing, of any respectable person, that a certain person is insane, and that the welfare of himself, or of others, requires his restraint, it shall be the duty of the judge to appoint, immediately, a commission, who shall inquire into and report upon the facts of the case If, in their opinion, it

is a suitable case for confinement, the judge shall issue his warrant for such disposition of the insane person as will secure the objects of the measure.

4. The commission provided for in the last section shall be composed of not less than three nor more than four persons, one of whom, at least, shall be a physician and another a lawyer. In their inquisition they shall hear such evidence as may be offered touching the merits of the case, as well as the statements of the party complained of, or of his counsel. The party shall have seasonable notice of the proceedings, and the judge is authorized to have him placed in suitable custody while the inquisition is pending.

5. On a written statement being addressed, by some respectable person, to any high judicial officer, that a certain person, then confined in a hospital for the insane, is not insane, and is thus unjustly deprived of his liberty, the judge, at his discretion, shall appoint a commission of not less than three nor more than four persons, one of whom, at least, shall be a physician and another a lawyer, who shall hear such evidence as may be offered touching the merits of the case, and, without summoning the party to meet them, shall have a personal interview with him, so managed as to prevent him, if possible, from suspecting its objects. They shall report their proceedings to the judge, and if, in their opinion, the party is not insane, the judge shall issue an order for his discharge.

6. If the officers of any hospital shall wish for a judicial examination of a person in their charge, such examination shall be had in the manner provided in the fifth section.

7. The commission provided for in the fifth section shall not be repeated, in regard to the same party, oftener than once in six months; and in regard to those placed in a hospital under the third section, such commission shall not be appointed within the first six months of their residence therein.

8. Persons placed in a hospital under the first section of this act, may be removed therefrom by the party who placed them in it.

9. Persons placed in a hospital under the second section of this act, may be discharged by the authorities in whom the government of the hospital is vested.

10. All persons whose legal status is that of paupers, may be placed in a hospital for the insane by the municipal authorities who have charge of them, and may be removed by the same authority, the fact of insanity, being established as in the first section.

11. On statement, in writing, to any high judicial officer, by some friend of the party, that a certain party, placed in a hospital under the third section, is losing his bodily health, and that consequently his welfare would be promoted by his discharge, or that his mental disease so far has changed its character as to render his further confinement unnecessary, the judge shall make suitable inquisition into the merits of the case, and, according to its result, may or may not order the discharge of the party.

12. Persons placed in any hospital for the insane, may be removed therefrom, by parties who have become responsible for the payment of their expenses; provided, that such obligation was the result of their own free

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act and accord, and not of the operation of law, and that its terms require the removal of the patient in order to avoid further responsibility.

13. Insane persons shall not be made responsible for criminal suit, unless acts shall be proved not to have been the result, directly or indirectly, of insanity.

14. Insane persons shall not be tried for any criminal act during the existence of their insanity; and for settling this issue, one of the judges of the court, by which the party is to be tried, shall appoint a commission, consisting of not less than three nor more than five persons, all of whom shall be physicians, and one, at least, if possible, an expert in insanity, who shall examine the accused, hear the evidence that may be offered touching the case, and report their proceedings to the judge, with their opinions respecting his mental condition. If it be their opinion that he is not insane, he shall be brought to trial; but if they consider him insane, or are in doubt respecting his mental condition, the judge shall order him to be placed in some hospital for the insane, or some other place favorable for a scientific observation of his mental condition. The person to whose custody he may be committed, shall report to the judge respecting his mental condition, previous to the next term of court; and if such report is not satisfactory, the judge shall appoint a commission of inquiry, in the manner just mentioned, whose opinion shall be followed by the same proceedings as in the first instance.

15. Whenever any person is acquitted in a criminal suit, on the ground of insanity, the jury shall declare this fact in their verdict; and the court shall order the prisoner to be committed to some place of confinement, for safe keeping, or treatment, there to be retained until he may be discharged in the manner provided in the next section.

16. If any judge of the highest court having original jurisdiction shall be satisfied, by the evidence presented to him, that the prisoner has recovered, and that the paroxysm of insanity in which the criminal act was committed, was the first and only one he had ever experienced, he may order his unconditional discharge; if, however, it shall appear that such paroxysm of insanity was preceded by at least one other, then the court may, in its discretion, appoint a guardian of his person, and to him commit the care of the prisoner, said guardian giving bonds for any damage his ward may commit: Provided, always, that in case of homicide or attempted homicide, the prisoner shall not be discharged, unless by the unanimous consent of the superintendent and the managers of the hospital, and the court before which he was tried.

17. If it shall be made to appear to any judge of the supreme judicial court, or other high judicial officer, that a certain insane person is manifestly suffering from the want of proper care, or treatment, he shall order such person to be placed in some hospital for the insane, at the expense of those who are legally bound to maintain him.

18. Application for the guardianship of an insane person shall be made to the judge of probate, or judge having similar jurisdiction, who, after a hearing of the parties, shall grant the measure, if satisfied that the person

is insane, and incapable of managing his affairs discreetly. Seasonable notice shall be given to the person who is the object of the measure, if at large, and if under restraint, to those having charge of him; but his presence in court, as well as the reading of the notice to him, may be dispensed with, if the court is satisfied that such reading, or personal attendance, would probably be detrimental to his mental or bodily health. The removal of the guardianship shall be subjected to the same mode of procedure as its appointment.

19. Insane persons shall be made responsible, in a civil suit, for any injury they may commit upon the person or property of others; reference being had in regard to the amount of damages, to the pecuniary means of both parties, to the provocation sustained by the defendant, and any other circumstance which, in a criminal suit, would furnish ground for mitigation of punishment.

20. The contracts of the insane shall not be valid, unless it can be shown, either that such acts were for articles of necessity, or comfort, suitable to the means and conditions of the party, or that the other party had no reason to suspect the existence of any mental impairment and that the transaction exhibited no marks of unfair advantage.

21. A will may be invalidated on the ground of the testator's insanity, provided it be proved that he was incapable of understanding the nature and consequences of the transaction, or of appreciating the relative values of property, or of remembering and calling to mind all the heirs-at-law, or of resisting all attempts to substitute the will of others for his own. A will may also be invalidated on the ground of the testator's insanity, provided it be proved that he entertained delusions respecting any heirs-at-law, calculated to produce unfriendly feeling towards them.

III.

THE AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION 1893-1913.

The forty-seventh meeting of the Association and the first under its new name of "The American Medico-Psychological Association," was held at Chicago, June 6, 1893. Dr. J. B. Andrews was president. Eighty-seven members were present, and nine persons by invitation.

The address of the president referred to a number of important subjects. Among them were suggested the desirability of a uniform course of study in training schools for nurses and attendants in hospitals; the better promotion of education in psychiatry and the relation of state institutions to political control.

Owing to the desire of the vice-president, Dr. Curwen, not to become president until the fiftieth anniversary of the founding of the Association in 1894, Dr. Andrews was re-elected president for another year.

Dr. Wise presented a paper on hopeful recoveries from insanity.

Dr. Matthew D. Field, of New York, in an interesting paper, called attention to the fact that the condition known in institutions among the insane as "hæmatoma auris" which had been regarded by many alienists as peculiarly belonging to the insane was not unknown to the ancients. He gave an account of the deformity appearing in the ears of the statue of an athlete discovered in Rome in 1887; and stated that similar deformities were not uncommon among acrobats, boxers, football players and school children whose ears had been subjected to violence. He also stated that similar deformities were found in the lower animals, especially in hunting dogs. He did not believe that the condition arose from a single blow but was due to repeated injuries. In the discussion which followed the impression seemed to be that the writer did not fully account for its great prevalence among the insane, especially among those who suffered from epilepsy and other degenerative troubles. not necessarily the result of violence or traumatism.

A paper was presented by Dr. Fisher, of Boston, upon "The New Boston Insane Hospital," in which he recommended that the title *asylum* and the word *insane* in the hospital be removed so that the stigma which is thus placed on institutions for the insane be done away with. He recommended the erection of two-story pavilion buildings upon the slow combustion or mill construction plan in cottages, which are self-contained, that is, provided with kitchen and dining-room. In the discussion it was evident that the trend of public sentiment seemed to be in favor of cheaper cottage buildings for the chronic insane.

A paper was also presented by Dr. N. Emmons Paine on instruction in psychiatry in the American medical schools.

Although the meeting was the forty-seventh in point of time, it occurred upon the forty-ninth year of the establishment of the Association. Commencing with the fiftieth year the newly organized American Medico-Psychological Association decided to publish an annual volume of transactions to contain a full record of the proceedings and papers of the Association.

The Association convened to celebrate the fiftieth year of its establishment in Philadelphia, May 15, 1894. Dr. Curwen was president. Ninety-eight members were present.

The principal event of the sessions was the address of the president, in which he gave a careful retrospect of the history of the Association during the previous 50 years. He also gave sketches of the lives and services of many of the men with whom he had been associated during that period. There were several historical addresses; one by Dr. Edward Cowles, "The Progress of the Care of the Insane During the Half Century"; another by Dr. W. W. Godding, of Washington, "The Development of the Present Hospital for the Insane"; a third by Dr. G. Alder Blumer, "A Half Century of American Medico-Psychological Literature"; and a fourth by Dr. T. W. Fisher, "New England Alienists During the Past Half Century."

Dr. S. Weir Mitchell in the annual address made severe criticisms upon the management of institutions for the insane throughout the country. He believed that boards of managers were not well constituted and that institutions were lacking in proper facilities for the care of the patients, or for the study of mental diseases. He deplored the absence of trained nursing, and urged the need of

electrical equipment, of hydro-therapeutic apparatus, and of laboratories. As he spoke before the Association by special invitation as a representative of the medical profession of Philadelphia, where the Association had been organized 50 years before, the members as courtesy demanded listened patiently to his arraignment and made no reply.

During the following year, however, several articles from members appeared in medical journals challenging the correctness of his conclusions; and all felt that they were unjust. The ultimate effect of the address was undoubtedly good and stimulated the newer men to greater activity in strictly medical lines.

A most useful paper was presented by Dr. J. W. Babcock, of South Carolina, on "Provision for Tuberculosis in Hospitals for the Insane," in which for the first time in the history of the Association the careful separation of tubercular from other patients was advocated, and the necessity of an absolute disinfection of rooms occupied by tuberculous patients to prevent the spread of the disease to other patients was insisted upon. This was the beginning of the widespread movement in the institutions to segregate the tuberculous in order to safeguard the health of other patients.

The fifty-first meeting of the Association was held in Denver, at the Brown Palace Hotel, in June, 1895. Dr. Edward Cowles, of Massachusetts, was president. Forty-four members and several trustees of institutions were present.

The presidential address related to "The Advancement of Psychology in America."

This was followed by an excellent paper from Dr. P. M. Wise on "Medical Work in Wards of Hospitals for the Insane." The discussion of this paper was unusually full and interesting.

A paper was also presented by Dr. George H. Rohé, on "Pelvic Disease in Women and Insanity," which elicited much discussion.

The fifty-second meeting of the Association was held at Boston, in 1896. Dr. Richard Dewey was president. One hundred and twenty-two members were present and 18 guests and visitors by invitation.

A report on training schools was presented which recommended the preparation and publication of a manual for the instruction of nurses. Although this recommendation was adopted the manual was never prepared.

A committee on the preparation of statistical tables presented a report accompanied by forms which were ordered printed for consideration at the next session. These forms were never adopted.

The presidential address of Dr. Dewey voiced the general sentiment that Dr. Mitchell's address of two years before had done scant justice to the work of the Association.

The annual address on "Psychological Education" was by President G. Stanley Hall, of Clark University.

An interesting paper was presented by Dr. Carlos F. MacDonald on "State Care and Maintenance for the Dependent Insane in New York."

There was also a valuable paper by Dr. Frederick Peterson on the "Psychology of the Idiot."

The fifty-third meeting was held at Baltimore, on May 11, 1897. Dr. T. O. Powell was president. Ninety members were present and many other persons as guests and visitors by invitation.

One of the most important addresses was that of the president, entitled: "A Sketch of Psychiatry in the Southern States." Dr. Powell had taken great pains to collect information as to the early history of many institutions and to preserve such traditional details as can only be furnished by men who were familiar with the early history of the different states.

An interesting discussion occurred upon "After-Care of the Insane," initiated by Dr. Richard Dewey, of Wisconsin, and participated in by Drs. Hill, Godding, Gilman and Hoyt. A resolution was adopted favoring the movement, and requesting the president to appoint a committee upon after-care to co-operate with a similar committee of the American Neurological Association.

A paper was presented by Dr. P. M. Wise on "Training Schools for Nurses in Hospitals for the Insane."

There were also papers on "The Medical and Material Aspects of Industrial Employment for the Insane," by Dr. G. Alder Blumer, and on "Commitment and Detention of the Insane," by Dr. E. N. Brush.

The annual address was given by Dr. Bernard Sachs, of New York, on "Advances in Neurology and Their Relation to Psychiatry."

The fifty-fourth annual meeting of the Association was held at St. Louis, May 10, 1898. The president was Dr. R. M. Bucke, of

Canada. Sixty members were present, and 13 other representatives of institutions, visitors and guests were present by invitation.

The presidential address by Dr. Bucke was on "Surgery Among the Insane in Canada," which gave an account of surgical work which had been done principally upon women in his institution at London, Ont. He was of the opinion that much benefit had resulted from surgical operations in gynecological diseases, and recommended that an effort be made to extend the work to other similar institutions in Canada.

The annual address was delivered by Dr. J. T. Eskridge, of Colorado, on "The Relations Between Alienists and Neurologists in the Study of Psychiatry and Neurology." The paper was of unusual interest because it was the first presented before the Association which foreshadowed the requirements of the present intensive scientific study of insane conditions. He believed that there should be one resident physician for every 25 patients, and also a psychologist, pathologist, medical director and a training school for nurses in every hospital for the insane. At the time the address was delivered the proposition seemed to be an ideal absolutely unattainable; in the light of present conditions it does not seem visionary.

There were papers on "The Care of the Chronic Insane," by Drs. H. A. Gilman and B. D. Eastman; also on "The Wisconsin County Care System," by Dr. W. B. Lyman. The discussions were full and interesting.

The fifty-fifth meeting of the Association was held in New York, May 23, 1899. Dr. Henry M. Hurd, of Maryland, was president. One hundred and fifty-three members were present, also 23 other persons connected with institutions as visitors and guests by invitation.

The presidential address was on "The Teaching of Psychiatry." The annual address, delivered by Dr. Frederick Peterson, of New York, was on "The Problems of Psychiatry." It was an earnest plea for psychopathic hospitals where insanity could be treated in its early stages, and the disease more carefully studied; also for the establishment of colonies. He urged that institutions for the chronic insane should be made more attractive and that occupation should be furnished for patients.

A paper was presented by Dr. Carlos F. MacDonald on "Legal Versus Scientific Tests of Insanity in Criminal Cases."

Dr. John B Chapin, of Philadelphia, presented a paper on the "Psychology of Criminals," which contained a plea for better medical service in prisons.

Dr. G. Alder Blumer presented a paper on "The Care of the Insane in Farm Dwellings."

The fifty-sixth meeting of the Association was held at Richmond, Va., May 22, 1900. Dr. Joseph G. Rogers, of Indiana, was president. Ninety-eight members were present, also 23 trustees and other persons representing institutions.

The address of the president was on "A Century of Hospital Building for the Insane," in which he gave the results of his large experience as a builder of hospitals, not only as to plans and distribution of buildings, but also as to the material to be used in building and the manner of construction. He entered into details as to floors, wall surfaces, woodwork, doors, window-sashes, lights and systems of heating and ventilation. The address was of great interest and value.

The annual address was given by Dr J. Allison Hodges, of Richmond, upon "The Effect of Freedom Upon the Physical and Psychological Development of the Negro," in which he took a discouraging view of the future of the race. His conclusions were that the negro was "designed by God and nature to remain a white man's servant," and must be kept in a condition of peonage and training until he acquired the qualities which he lacked.

Many papers were presented but most of them related to details of treatment.

The fifty-seventh meeting of the Association was held at Milwaukee, Wis., June 11, 1901. Dr. P. M. Wise, president of the New York State Lunacy Commission, was president. Eighty members were present, also 29 persons interested in the care of the insane and other guests.

The address of the president, which was general in character, urged the establishment of psychopathic hospitals for the treatment of acute cases. He expressed the opinion that the present system of committing patients to institutions prevented the majority of incipient cases from being placed where proper treatment and relief could be obtained at a time when it was possible to do them good. This was the first official statement to this effect made before the Association by a presiding officer.

The annual address was delivered by Professor W. P Lombard, of the University of Michigan, on the "Reinforcement and Inhibition of Nervous Processes."

There was also a special paper by Dr. W. J. Mayo, of Rochester, Minn., on "Limitations of Surgical Work for the Insane," in which he gave the results of his experience in the operative treatment of traumatic epilepsy. The general conclusions were not favorable to surgical operations as curative measures in epilepsy.

Dr. Henry C. Baldwin, of Boston, presented a paper on the "Need of Better Provision for the Care of Cases of Delirium Tremens and of Doubtful Mental Disease," which contained a plea for the establishment of a special institution in each city, either as a separate hospital or in connection with general hospitals, for the care of such cases. In the discussion which followed a general approval was given of the proposal, and mention was made of several cities where such provision already existed.

A paper was also presented by Dr. D. R. Brower on the treatment of acute insanity in special wards in general hospitals, in which he urged that admission to such wards should be as free as that of other patients In the discussion which followed it was evident that the proposition did not meet with general approval, and some members seemed to think that the construction of such hospitals might be viewed as a criticism upon existing hospitals for the insane. In reply Dr. Brower said that whatever criticism might be made, it was evident that the proposition to establish such hospitals had already taken hold upon the public mind, and that in the future they would undoubtedly be established—a prophecy which has already been realized.

The fifty-eighth meeting was held at Montreal, June 17, 1902. Dr. R. J. Preston, of Virginia, was president. Eighty-six members were present, and 23 physicians, trustees, medical officers or visitors were present by invitation.

The address by the president was upon "The Development of the Care of Mental Diseases in the United States and Canada." Among many other interesting statistics were the following:

The population of the United States at the close of the ninth census of the eighteenth century (1790), just after the ratification of the Constitution by the 13 original states, was something near four millions. Three additional states (Vermont, Kentucky and Tennessee) were admitted during

the last decade of the eighteenth century, and at the beginning of this[1] century the population had increased to five and one-third millions, or 35.10 per cent. In the first decade only one state (Ohio) was admitted, but the population had increased to nearly seven and one-third millions, or 36.38 per cent. During the second decade five states (Louisiana, Indiana, Mississippi, Illinois and Alabama) were admitted, and the population had increased to over nine and one-half millions, or 33.07 per cent. During the third decade two states (Maine and Missouri) were admitted, and the population had increased to a little over twelve and two-thirds millions, or 33.88 per cent. In the fourth decade two states (Arkansas and Michigan) were admitted, and the population had increased to a little over seventeen millions, or 32.67 per cent. In the fifth decade four states (Florida, Texas, Iowa and Wisconsin) were admitted, and the population had increased to a little over twenty-three millions, or 35.87 per cent. In the sixth decade three states (California, Minnesota and Oregon) were admitted, and the population had increased to nearly thirty-one and one-half millions, or 35.58 per cent. In the seventh decade four states (Kansas, West Virginia, Nevada and Nebraska) were admitted, and the population had increased to over thirty-eight and one-half millions, or 22.63 per cent. In the eighth decade only one state (Colorado) was admitted, but the population had increased to a little over fifty millions, or 30.08 per cent. In the ninth decade four states (North Dakota, South Dakota, Washington and Montana) were admitted, and the population had increased to over sixty-two and one-half millions, or 24.86 per cent. In the tenth decade three states (Wyoming, Utah and Idaho) were admitted, and the population had increased to over seventy-five and one-half millions, or 26.84 per cent. Considering this wonderful growth from 16 states and a population of 5,308,483 the first year of this century, to 45 states and a population of 75,694,764 at the close of the last year of the nineteenth century, what may we not expect for the incoming century?

During the third decade, the second, third and fourth state asylums to be established in the United States were the Eastern Asylum, Lexington, Ky., opened in 1824, the South Carolina Asylum, Columbia, opened in 1828, and the Western Asylum, Staunton, Va., opened in 1828. During the fourth decade six state asylums were opened. During the fifth decade nine state and four private asylums for the insane were opened.

In 1850 the insane population in state institutions was given at 15,610. During the sixth decade 19 state and five private asylums were opened, and the insane population had increased to 24,042, or 54 per cent. During the seventh decade 21 state and six private asylums were opened, and the insane population had increased to 37,432, or 55 per cent. During the eighth decade 31 state and ten private asylums were opened, and the insane population had increased to 91,959, or 145 per cent. During the ninth decade 37 additional state and 17 private hospitals were established, and the insane population had increased to 106,485, or 16 per cent. During the tenth decade 21 additional state and 28 private hospitals were opened.

[1] The Nineteenth Century.

The first asylum for the insane in Canada, the Provincial Asylum, at St. John, N. B., was opened November 14, 1835.

In the fifth decade, to use dates corresponding with those in the United States, two asylums for the insane were opened, the Provincial Asylum, Toronto, Can., opened June 31, 1841, and the Beauport Asylum, of Quebec, opened in 1845. At the beginning of the nineteenth century (1800) the population of Canada was 240,000. At the beginning of the fifth decade (1840) the population of Canada was less than one million.

During the sixth decade two hospitals for the insane were opened, Rockwood Hospital, Ontario, 1855, and Nova Scotia Hospital, Halifax, N. S., 1858.

During the seventh decade (1861 to 1871) two asylums were opened at Quebec, in 1868, and London Asylum, London, Ont., in 1870. The population of Canada in 1871 was 3,485,751.

During the eighth decade five asylums were opened, Provincial Asylum, New Westminster, B. C., 1873; Asile de St. Jean de Dieu, Longue Pointe, Que., rebuilt, 1873; St. Julien Asylum at St. Ferdinand, Que., 1873; Hamilton Asylum, Hamilton, Ont., 1876; Hospital for Feeble-Minded, Orillia, Ont., 1876; Prince Edward Island Hospital, Charlottetown, P. E. I., 1879. The population in 1881 was 4,324,810.

During the ninth decade two asylums were opened, Homewood Retreat, Guelph, Ont., 1883; Selkirk Asylum, Selkirk, Man., 1885. The population in 1891 was 4,833,239.

During the tenth decade (1891 to 1901) four asylums were opened, Protestant Asylum, at Verdun, near Montreal, 1890; Brockville Asylum, Brockville, Ont., 1894; Asylum for the Insane, Brandon, Man., 1891; Asylum for the Insane, Cobourg, Ont., 1901. The population in 1901 was 5,338,893. There are at this time 16 hospitals for the insane in Canada or British America.

The annual address was delivered by Professor Wesley Mills, of McGill University, on "Reflexes and Their Psychiatric Correlatives." This lecture was illustrated by many lantern slides, and was of true scientific value.

An important paper was presented by Dr. Emmett C. Dent, of New York, on "Hydriatic Procedures an Agency in the Treatment of Insanity." It gave interesting historical details as to the employment of water, and also entered into careful descriptions of the methods used and spoke of the great importance of water as a therapeutic agent. In the discussion which followed it was made apparent that many institutions had established hydrotherapeutic outfits and that great advantage had come to patients from their use.

Dr. Owen Copp, of Massachusetts, gave an excellent paper on the results and possibilities of family care of the insane in Massa-

chusetts, which elicited a discussion and indicated that the members of the Association were not agreed upon the advisability of family care.

Papers on "Tent Life for the Uncleanly Insane," by Dr. Wright, and "Tent Life for the Tubercular Insane," by Dr. Haviland, were presented.

The fifty-ninth meeting of the Association was held in Washington, May 12, 1903.

The president was Dr. G. Alder Blumer, of Rhode Island. One hundred and ninteen members were present, and 24 persons representing boards and others interested in the treatment of the insane were present as guests by invitation.

The presidential address related largely to certain movements in progress in various states to improve the care of the insane. The president deprecated the evils of centralization in the control of institutions, and also suggested certain measures which were calculated to prevent the increase of insanity, such as the prevention of marriages of consanguinity, the exclusion of defective emigrants and the prohibition of the marriage of feeble-minded persons.

There was no annual address. An interesting feature, however, was a personal reminiscence by Dr. Stephen Smith, of the late Amariah Brigham, entitled: "How Dr. Brigham Met the Challenge to Diagnose Insanity at Sight."

A symposium was held upon the status of the insane criminal, after the reading of papers by Dr. H. E. Allison, entitled: "Hospital Provision for the Insane Criminal"; by Dr. Frank W. Robinson, "Recognition of the Insane in Penal Institutions," and by Dr. Robert B. Lamb, "The Mind of the Criminal." The discussion was valuable as presenting the great need of careful attention to the mental condition of persons in penal institutions, and the growing conviction that many convicts were mentally defective or insane.

An interesting paper was presented by Drs. Wright and Haviland, entitled "Additional Notes Upon Tent Treatment."

The first paper to be presented to the Association on "Blood-Pressure" was by Dr. William Rush Dunton, Jr.

Dr. L. Pierce Clark presented an account of the newest psychopathic hospital at Kiel, Germany.

In the business sessions of the Association after discussion and general consideration of the subject, it was voted that the Association become a member of the Congress of American Physicians. This action required that the Association should meet every third year in Washington.

The sixtieth meeting of the Association was held in St. Louis, May 30, 1904. Dr. A. B. Richardson, of Washington, who had been elected president, died in the interval between his election and taking office. The vice-president, Dr. A. E. Macdonald, of New York, was accordingly elected to fill the vacancy. Eighty-seven members were present at the meeting, and 14 visitors and guests by invitation.

The presidential address by Dr. Macdonald related to topics of general interest in the care of the insane.

The annual address, given by Dr. Charles G. Chaddock, of St. Louis, was a review of the relations of the mind and the nervous system.

A paper presented by Dr. E. Stanley Abbott, of the McLean Hospital, gave an account of the rapid extension of observation wards and psychopathic hospitals in this country and abroad.

An interesting paper on the training of nurses was presented by Dr. C. P. Bancroft, in which he presented a plan for the better training of nurses for the insane.

A paper by Dr. George T. Tuttle, of the McLean Hospital, on "Hydrotherapy," gave many practical details as to its employment in institutions.

The sixty-first meeting of the Association was held at San Antonio, Texas, April 18, 1905. Dr. T. J. W. Burgess, of Montreal, was president, and Dr. E. C. Dent, who had been elected to succeed Dr. Burr, was secretary.

Forty-eight members were present, also 39 visitors and guests were registered.

The presidential address was on "The Insane in Canada," and gave a review of the conditions in the different provinces of Canada. The statistics as to the number of insane were very interesting:

In 1901, according to the census of that year, there were in the Dominion of Canada 16,622 persons of unsound mind, being a ratio of 3.125 per thousand, or about 1 in every 319 of a population numbering 5,318,606 souls, exclusive of the unorganized territories. Of these 16,622 defectives, 10,883

were inmates of asylums or other institutions, making a percentage of .642 per cent under care.

The provinces as regards the number of their insane stood as follows: Prince Edward Island 361, a proportion of 3.496 per thousand; Ontario 7552, or 3.459 per thousand; New Brunswick 1064, or 3.213 per thousand; Quebec 5297, or 3.212 per thousand; Nova Scotia 1403, or 3.052 per thousand; Manitoba 464, or 1.818 per thousand; British Columbia 301, or 1.684 per thousand; Northwest Territories 180, or 1.132 per thousand.

With respect to custodial care, British Columbia ranked first, having under care at the close of 1901 no less than 94 per cent of the total number of those mentally incapacitated; Manitoba came next with 77 per cent in safe-keeping; Nova Scotia stood third with 71 per cent sheltered; Ontario was fourth with 69 per cent in asylums; Prince Edward Island was fifth with 61 per cent provided for; Quebec and Northwest Territories were equal with 58 per cent under care; and New Brunswick was eighth with 52 per cent housed.

The following table shows the changes indicating increased custodial care, or otherwise, on the part of the several provinces, in the decade extending from 1891 to 1901. By this it will be seen that there had been a marked advance in all with the exception of New Brunswick, which remained unchanged:

Provinces.	In Asylum 1891.	In Asylum 1901.
British Columbia	90 per cent	94 per cent
Manitoba	55 " "	77 " "
New Brunswick	52 " "	52 " "
Nova Scotia	36 " "	71 " "
Ontario	58 " "	69 " "
Prince Edward Island	38 " "	61 " "
Quebec	50 " "	58 " "
Northwest Territories (housed in Manitoba asylums)		58 " "
Canada	54 per cent	66 per cent

He further deplored the fact that Canada had been made the dumping ground for defective emigrants, and gave in support of this statement the following statistics:

In proof that what I have said is no exaggeration of the ill effects attendant upon immigration insufficiently safeguarded, let me call your attention to some figures bearing on the subject. By the census of 1901 the population of Canada was 5,371,315, the number of foreign-born being 699,500; the total of the insane was 16,622, and of these 2878 were foreigners. From these returns it will be seen that a little over 13 per cent of the general population—that is to say, the imported element—furnished over 17 per cent of so-called Canadian lunacy. Stated in another form, if the native Canadians alone are considered, there is 1 insane person in every 339 of the population; while the proportion among the foreign element is 1 in every 243.

If further evidence were needed I would say that during the year 1903 there were admitted to Canadian asylums 2213 insane persons. Of this number 1726 were born in Canada. The remaining portion, 487, representing 22 per cent of the admissions, was foreign-born. At Verdun, 2148 patients have been received since the opening of the establishment, and of this number 40 per cent were of foreign birth. In the same institution there are at present time no less than 30 persons in a population of 460, who, if subjected to anything but the most cursory examination, would never have been allowed to set foot in the country.

He also deprecated the prevalence of political control, and said that in the 18 hospitals of Canada the superintendents of 12 owed their appointment to political influence rather than to their attainments in psychiatry.

The annual address was presented by Dr. J. T. Searcy on "Tripartite Mentality," and was metaphysical in character.

Papers were presented by Dr. H. W. Miller on "Huntingdon's Chorea"; by Dr. Arthur W. Hurd on "Korsakoff's Psychosis."

An interesting paper on "The Relations of Surgery to Insanity" was presented by Drs. Leroy Broun and John R. Knapp.

The sixty-second meeting of the Association was held in Boston, June 12, 1906. Dr. C. B. Burr, of Michigan, was president. One hundred and twenty-four members were present, and 81 guests were present by invitation.

Owing to the death of Dr. E. C. Dent, the former secretary, Dr. Charles W. Pilgrim was made secretary.

The presidential address was on "The Physician as a Character in Fiction."

The annual address was delivered by Prof. R. S. Woodward on "Psychiatry and Experimental Psychology," and was a plea for the study of psychiatry by the methods of experimental psychology.

Several papers were presented on the subject of nurses in hospitals for the insane. Dr. Bancroft discussed women nurses in male wards of hospitals. Dr. Tuttle spoke of the male nurse, Dr. C. R. Woodson of night nursing for the insane, and Dr. R. B. Lamb of the training school in insane hospitals. The discussion of these papers showed that great improvements had been made in the nursing of the insane, and the training of both men and women as nurses during the past few years.

Dr. Copp presented a paper on "Further Experience in Family Care of the Insane in Massachusetts."

Dr. George A. Smith gave a valuable paper on the "Cottage System."

Dr. John Koren, in a paper on the statistics of the insane, spoke of the difficulty which he met in his endeavor to make use of the statistical details in hospital reports. He deplored their lack of uniformity, the over elaboration of trivial details, and the large mass of material which could not be used. He believed that the assigned causes of insanity were fanciful and the statistics of recoveries were not reliable. It is much to be regretted that this paper bore no fruit.

The sixty-third meeting of the Association was held at Washington, May 7, 1907. Dr. Charles G. Hill, of Maryland, was president. Eighty members were present, and 38 visitors and guests of the Association.

Before the completion of its session, the Association adjourned to reconvene at the Jamestown Exposition, and the meetings of the last day were held there.

The presidential address of Dr. Hill had for its subject "How Can We Best Advance the Study of Psychiatry?" In this he made a plea for a more intensive study of mental disease, and of the effects and abuses of remedies. He believed that in medical education greater attention should be given to diet, the digestion of food, the chemical composition of food, the production of physiologic sleep, etc., and that a practical application of mental therapy would much increase the usefulness of institutions.

A most important paper was a report of a committee on training schools for nurses, in which practical suggestions were made as to the organization of schools, the qualifications of pupils, the compulsory education of all persons engaged in nursing service, and the instruction of attendants who are not fitted to join the school and who do not undertake responsible nursing work. The committee believed that nurses should have a knowledge of anatomy, physiology and psychology, personal hygiene, the germ theory of disease, the appearance of drugs and their methods of administration and their effects, also a practical knowledge of cooking for the sick, massage, hydrotherapy, and the more common medical and surgical diseases, including contagious diseases, the diseases of children, nervous diseases and insanity. It was

also recommended that nurses should learn general as well as special nursing, the former in general hospitals; that instruction should be given by lectures, demonstrations, etc.; that there should be rotation in the various branches of service; that the proficiency of pupils should be tested by examination; and that the length of the course should be at least two years, and preferably three years. A preliminary course of instruction was also suggested. A diploma should finally be given to every nurse who completes the course.

Two important papers on after-care of the insane were presented by Dr. Robert M. Elliott and Dr. William Mabon respectively. In the discussion which followed several instances were cited of the benefit which had followed after-care.

Three papers were presented on reception hospitals and psychopathic wards by Drs. Adolf Meyer, C. P. Bancroft and M. S. Gregory. In the discussion of the papers much additional information respecting the success of efforts to establish such wards in Canada, Michigan, Ohio and Iowa was elicited.

An interesting paper was presented by Dr. Alfred I. Noble, of Michigan, on "Shorter Hours for Nurses," in which he recommended that the nurse's day be eight hours, and that her time be so arranged as to secure the maximum of service at a time when it was most required by patients.

The sixty-fourth meeting of the Association was held at Cincinnati, Ohio, May 12, 1908. The president was Dr. C. P. Bancroft, of New Hampshire. Ninety-one members were present, and 29 visitors and guests of the Association.

The presidential address of Dr. Bancroft was entitled "Hopeful and Discouraging Aspects of Psychiatric Outlook." He believed that the remarkable scientific study of psychiatry during the past few years had accomplished great good, as also the especial attention given to sociology and to the treatment of insanity. He believed that improvements had occurred in buildings, in better training of nurses, in the establishment of psychopathic wards and in improved methods of teaching psychiatry. He expressed the opinion that a clearer understanding of the etiology of insanity emphasized the importance of more strict and careful attention to the prevention of mental disease. He recommended a closer medical inspection of prisons and jails and greater care to prevent the admission of undesirable emigrants. He also recommended

that efforts be made by the Association to place medical expert testimony on a higher plane.

The annual address was delivered by Hon. Judson Harmon, Governor of Ohio. It was general in character but contained excellent suggestions as to the improvement of expert testimony.

A pathological paper was presented by Drs. Southard and Mitchell, which gave an anatomical analysis of cases of insanity with reference to the incidence of arteriosclerosis, senile atrophy and the distribution of pigments in brain tissue.

Dr. Ferris, president of the New York Lunacy Commission, presented a paper on Italian immigration and insanity.

Dr. B. T. Sanborn, of Maine, presented interesting data in reference to insanity in the rural districts of Maine, from which it appeared that insanity in Maine was diminishing, a fact which he ascribed in part to a prohibitory law. In the discussion which followed Dr. Mitchell stated that at the Bangor Insane Hospital alcoholic insanity existed in less than 5 per cent of the men admitted, while at Danvers Hospital 18 per cent or 20 per cent of such cases were admitted. He believed that a lack of foreign immigration had much to do with the diminution of insanity in the State of Maine.

The sixty-fifth meeting of the Association was held at Atlantic City in June, 1909. Dr. Arthur F. Kilbourne, of Minnesota, was president. One hundred and twenty-one members were present, and 38 guests and trustees by invitation.

Owing to the recent illness of the president no presidential address was presented.

The annual address was by Prof. I. Woodbury Riley, of Vassar College, Poughkeepsie, N. Y., on "Mental Healing in America." He gave a sketch of the different forms of mental healing, including New Thought, Christian Science, and what has been known as the Emmanuel Movement. He closed with an appeal to the Association to educate the public and to lead it away from a blind worship of magic in medicine, and to revive the teachings of the early American schools, especially that of Rush, which emphasized the co-ordinate study of the mind as well as of the body.

An interesting paper was presented by Dr. John B. Chapin on the "Insanity Defense for Crime."

Dr. Ferris, president of the New York Lunacy Commission, presented a paper on "Border-Land Cases of Insanity and the Voluntary Patient," one of the first papers to be presented upon the subject. This elicited considerable discussion and brought out the fact that in New York, Massachusetts, Maryland and Minnesota provision already existed for the admission of voluntary patients.

An interesting paper was presented by Drs. C. H. Lavinder, C. F. Williams, and J. W. Babcock on the prevention of pellagra in the United States.

Two pathological papers were also presented, one by Dr. McGaffin entitled "Anatomical Analysis of 70 Cases of Senile Dementia"; the other by Dr. E. E. Southard on "Anatomical Findings in Senile Dementia."

The sixty-sixth meeting was held at Washington, May 3, 1910. Dr. W. F. Drewry, of Virginia, was president. One hundred and twenty-four members were present, and 31 visitors and guests by invitation. Dr. Charles G. Wagner was made secretary in place of Dr. C. W. Pilgrim, who had been elected vice-president.

In the presidential address on "The Scope of the Activities of the Alienists," eugenics, the restriction of alcoholic excesses and abuses, and the better regulation of social diseases were discussed.

The annual address by Professor A. F. Dressler, of Alabama, was on "The Psychology of Superstition."

The Committee on Expert Testimony presented an elaborate report in which it was recommended that in the presentation of the hypothetical question the evidence on both sides should always be included. It was also recommended that there should be consultations between medical witnesses as to the mental status of a patient suspected of insanity. In doubtful cases it was recommended that the question of insanity be tested by a period of hospital observation for a longer or shorter time, as the best method of arriving at the truth.

Following this Dr. C. F. MacDonald presented an excellent paper on the "Ethical Aspects of Expert Testimony."

Dr. Austin Flint, of New York, presented a paper on "Methods of Dealing with the Criminal Insane."

A departure in the papers usually presented was a paper on "Military Psychiatry," by Dr. R. L. Richards, of the United

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States Army Medical Corps, then detailed for service in the Government Hospital at Washington.

There were also two papers on pellagra, one by Dr. J. W. Babcock and the other by Dr. M. L. Perry.

The sixty-seventh meeting of the Association was held at Denver, Colo., June 19, 1911. Dr. Charles W. Pilgrim, of New York, was president. Fifty-eight members were present, and 19 visitors and guests of the Association.

The presidential address was on the "Care and Treatment of the Insane in the State of New York." It was an interesting record of the development of state care. Very appropriate tributes were also paid to eminent men, now deceased, who had been connected with New York institutions.

The annual address was delivered by Hon. Alva Adams, of Colorado.

An important paper by Dr. Robert L. Richards was " A Study of Military Offenses Committed by the Insane in the United States Army During the Past Fifty Years." This paper brought clearly before the Association an aspect of insanity and feeble-mindedness which had never been previously considered in this country, and emphasized the important part played by congenital weak-mindedness and mental defects in the offenses often punished in the army.

Allied to it also was a paper by Dr. W. W. Richardson, of Pennsylvania, on " Imprisonment Psychoses," with illustrative cases.

There was also an interesting series of papers on pellagra, by Drs. E. B. Saunders and J. W. Babcock, of South Carolina; on " The Treatment of Pellagra," by Dr. C. C. Bass; " Pellagra, in its Relations to Insanity and Nervous Diseases," by Dr. J. W. Mobley, of Georgia, and on " The Rapid Spread of Pellagra in the United States," by Dr. George A. Zeller, of Illinois.

In the paper by Dr. Babcock it was made evident that the disease had existed in South Carolina for many years. He presented the facsimile of a record of it in 1834 at the South Carolina State Hospital.

The paper by Dr. Bass was based largely upon the theory that pellagra was due to an infectious toxin generated in spoiled corn.

Dr. Mobley did not believe that the disease was due to a toxin from corn, but rather to a variety of causes acting upon the nervous system.

The paper by Dr. Zeller indicated that pellagra was much more prevalent in the Northern states than had heretofore been supposed.

The sixty-eighth meeting of the Association was held at Atlantic City, May 28, 1912. Dr. Hubert Work, of Colorado, was president. One hundred and twenty-three members of the Association were present, and 38 visitors, officers of institutions and guests by invitation.

The presidential address was " Psychologic Aspects of Insanity and Allied Defects." It contained a strong appeal for greater effort on the part of the Association to promote the study of eugenics, and touched upon several preventive measures of a surgical character which have not yet met the approval of all physicians.

The annual address by Hon. Herbert P. Bissell, of New York, was entitled " A Layman's View of the Care and Treatment of the Insane in the State of New York," which contained many historical and interesting details as to the present methods employed in the institutions of that state.

An interesting paper was presented by Dr. James V. May, of New York, on "Immigration as a Problem in State Care of the Insane," which led to the appointment of a committee to prepare a memorial to be laid before Congress.

Dr. Richard Dewey, of Wisconsin, presented an interesting account of the " Jury Law for the Commitment of the Insane in Illinois," together with some account of Mrs. E. W. Packard, its author, and the later lunacy legislation in Illinois. This was followed by an interesting discussion upon the commitment of the insane.

An interesting symposium occurred upon " The Diversional Occupation of the Insane," " The Re-education of Dementia Præcox Cases," " The Industrial Training of Chronic Cases," and the " Occupational Nurse." These papers were by Drs. Herring, Haviland, LaMoure and Dunton.

There were two interesting pathological papers by Drs. Orton and Fuller, of Massachusetts.

An interesting and unusual paper upon " Insanity Among Indians " was presented by Dr. H. R. Hummer, Superintendent of the Government Hospital for Insane Indians in North Dakota.

There was also a valuable paper on "The Treatment of the Insane in British Columbia," by Dr. Charles A. Doherty.

The sixty-ninth meeting of the Association was held at Niagara Falls, Canada, June 10, 1913. Dr. James T. Searcy, of Alabama, was president. One hundred and thirty-eight members were present, and 55 trustees, medical officers and visitors were present by invitation.

The presidential address by Dr. Searcy was on the topic, "Have We a Specialty?" in which he reviewed the work of those interested in the treatment of insanity, in the study of backward children, the feeble-minded and imbecile, and in the effects of drugs and alcoholics upon the race, and showed the great importance of such study for all men engaged in treating insanity.

The annual address was by Dr. Edward Ryan, of Kingston, Ont., upon "The More Modern Work of Institutions for the Insane."

An important paper on the "Statistical Study of the Insane," by Dr. James V. May, of the New York State Hospital Commission, analyzed the recent statistics of the State of New York. In the year 1911 the statistics gathered by the New York State Hospital Commission were so arranged as to become of great value to the state in their representation of what was actually happening to the insane. The statistics for the years 1911 and 1912 showed that the ratio of insane in New York to the general population was 1 to 282; the ratio of males being 1 to 293; and of women 1 to 269. This preponderance of women in institutions was ascribed to the greater longevity of women owing to the facts that alcoholic psychoses and general paresis were diseases which prevailed very much more largely among men than women. Two hundred and ninety-seven voluntary patients had been admitted during the year, of which 129 were readmissions. Of the 297 voluntary patients, 53 were subsequently committed to institutions. The number of patients discharged on parole from the various institutions during the year was 905. The number of criminal insane in state hospitals was 4 per cent of the population. The insane population in the state in 1912 was 31,624. The increase from 1890 to 1900 had been at the rate of 47.7 per cent. During the same period the general population had increased 21.2 per cent. From 1900 to 1910 the increase of insanity was 37.8 per cent, while the increase of

general population had been 25.4 per cent. From 1910 to 1912 the population of the state had increased more rapidly than the census of the insane. Of 4046 discharges during 1912, 1610 were regarded as recovered. The recovered per 100 admissions during the year was 21.9 per cent. Of 7283 admissions during the year 52.39 per cent were of native birth, and 47 per cent were of foreign birth; 22.12 per cent were of native parentage, and 73.29 per cent were of foreign or mixed parentage, and 4 per cent were of unknown parentage. Of the patients of foreign birth 23.1 per cent were born in Ireland; 15.3 per cent in Germany; 13.6 per cent in Russia; 9.8 per cent in Italy; 8.4 per cent in Austria; 5.6 per cent in England; 4.4 per cent in Hungary; 3.7 per cent in Canada; 2.1 per cent in Poland.

The paper contained valuable and interesting statistics and closed with a plea for the adoption of uniform statistics by all insane institutions of the different states so that the results might be comparable.

A paper was presented by Dr. E. Stanley Abbott on "Psychology and the Medical School," which brought out strongly the fact that psychology was not taught as any part of the curriculum of the medical schools, and in but three schools was a knowledge of it required for entrance.

Dr. Arthur H. Harrington presented an elaborate paper on the "Congregate Dining-Room and its Management," containing many details as to the practical management of congregate dining-rooms. He believed that in addition to securing greater efficiency in serving food they also were an excellent therapeutic measure for patients of all classes because they tended to establish habits of order and self-control.

An important paper on "A Proposed Change in the Criminal Law" was presented by Dr. Charles H. North, of the Dannemora Criminal Hospital. In this he recommended a change of the ordinary pleading in cases of murder where insanity has been pleaded as a defense from "not guilty by reason of insanity" to "guilty but insane." In the discussion which followed it was apparent that those members who were interested in medical-legal questions were not prepared to accept the position taken by the writer.

A carefully prepared paper by Dr. H. J. C. Kuhlman, of Buffalo, was entitled "The Father Complex." It was an elaborate presentation of the results of psycho-analysis.

A paper by Dr. Frank Woodbury on "Benjamin Rush, the Patriot, Physician and Psychiatrist," was appropriate in view of the fact that 1913 was the centennial anniversary of his death.

A report of the Committee on Medical and Scientific Work in Hospitals in the United States and Canada, prepared two years before by Dr. Adolf Meyer, was presented for publication in the *Transactions*. The investigation covered an inquiry into the general type of organization for the care of the insane in the various states, and a special inquiry into methods of medical care. The committee expressed the opinion that in states where a special commission existed there was the best showing in the work of individual institutions. The committee also believed that there was a decided growth in the direction of hospital rather than custodial care. The fact that the number of physicians was obviously too small in many institutions to do the work required by modern psychiatry was deplored. The conclusions of the committee in reference to the nursing problem were not definite. The committee deplored the lack of efficient after-care and preventive work.

Several sample reports of institutions had been prepared for presentation in connection with the report, but unfortunately they had been lost in transmission and could not be reproduced.

IV.

THE AMERICAN JOURNAL OF INSANITY.

In May, 1844, Dr. Amariah Brigham, the first superintendent of the State Lunatic Asylum at Utica, wrote to Dr. Pliny Earle, then superintendent of the Bloomingdale Asylum, a letter making the following announcement:

> I am about starting an American journal of insanity, quarterly, octavo, 96 pages, edited by the officers of this asylum. The first number will be out early in July. It is intended for the general reader as well as for the profession. This is a strict secret as I have mentioned it to no one but Dr. Beck, of Albany.

The projected *American Journal of Insanity* appeared in accordance with Dr. Brigham's plan in July, and was the first journal in the English language founded at private expense and devoted to mental medicine. Dr. Blumer well remarks:

> In view of the multiplicity of his duties as the head of a large institution as yet imperfectly organized as well as the precariousness of his health, it was a great and laudable undertaking.
>
> It is a matter of history that he suffered alike in pocket and in health by the enterprise, but he has left us a monument of his genius and energy which cannot fail to rebuke and incite those who in the face of pressing administrative work too prone to find an excuse for the sacrifice of professional aspirations and a plea of literary and scientific indolence.[1]

This *Journal* soon became the organ of the whole specialty of insanity in this country. It reported the papers and discussions of the Association and served to concentrate and strengthen the spirit of scientific investigation. Dr. Brigham, notwithstanding his ill health, edited the *Journal* for four years. Upon his death the managers of the Lunatic Asylum assumed the responsibility of its publication, and placed it in the hands of Dr. T. Romeyn Beck, of Albany, one of their number, who edited it with great efficiency until 1855.

Dr. Beck was a man of unusual literary and scholarly qualifications, and the *Journal* under his guiding care lost some of its former popular features and became a more scholarly publication.

[1] *Am. Journal of Insanity,* Vol. 51, p. 40, 1894.

In the year 1855, by the resignation of Dr. T. Romeyn Beck and the appointment of Dr. John P. Gray as superintendent of the New York State Lunatic Asylum, the latter became the editor of the *Journal*. He was not a man of large scholarship or of any unusual literary training, but was eminently a forceful personality, with strong and decided views as to all matters of public policy in the care of the insane. During the succeeding 30 years he conducted the *Journal* largely as a personal organ for the promulgation of his own personal views. He had much able assistance in editorial work and broadened the scope of the periodical by devoting a greater degree of attention to medico-legal, therapeutical and pathological matters and accomplished much good work. He had an eager mind and was ambitious for the development of his work, but was at all times intolerant of the views of others. He filled a large place in the history of New York for more than a quarter of a century and for many years dominated public opinion. In the *Journal* he advocated mechanical restraint, approved of the so-called Utica crib, opposed separate provision for the chronic insane, favored the construction of the hospital for insane criminals in connection with the Auburn State Prison, contended fiercely for the purely physical basis of insanity, violently opposed the doctrine of moral insanity, advocated the teaching of psychiatry in the medical schools; and was the first among American superintendents to encourage pathological research in his institution. During a portion of his editorship the *Journal* failed, by reason of his pronounced views, to secure the active co-operation of men like Pliny Earle, Isaac Ray, Edward Jarvis or Luther V. Bell, and became increasingly the organ of the so-called "Utica School." He had the assistance of Drs. Cleveland, Kellogg, Andrews, Kempster, Kitchen, Pilgrim, Blumer, Brush and other equally able men in the conduct of the *Journal*.

The successor of Dr. Gray was Dr. G. Alder Blumer who, in 1886, entered upon the duties of editor with much enthusiasm. He changed the form of the *Journal*, added to its departments and broadened its scope. He introduced letters from foreign correspondents, and systematized the collection of news items from the different institutions of the country, and thus enabled all institutions to announce to the public what they were doing and to learn what others were doing. The *Journal* became consequently

the organ of the whole Association to an extent which had never obtained before.

At the time when the institutions of New York were placed under the control of the Lunacy Commission there developed a possibility that the *Journal* might become the organ of the new commission, and in a measure cease to represent the profession of the entire United States. The Council of the Association consequently, after negotiation with the managers of the Utica State Hospital, purchased the *Journal* and arranged for its conduct by a Board of Three Editors, Edward Cowles, of Boston; Henry M. Hurd, of Baltimore, and Richard Dewey, of Chicago, managing editor. The office of publication of the *Journal* was removed to Chicago in 1894, and three annual volumes were published under Dr. Dewey's editorship.

Unfortunately, an extreme pressure of other imperative work compelled him to retire from the position and a new Board of Editors, consisting of G. Alder Blumer, of Providence; E. N. Brush, of Baltimore; J. Montgomery Mosher, of Albany, and Henry M. Hurd, of Baltimore, was appointed by the Council. The office of publication was then removed to Baltimore and placed in charge of The Johns Hopkins Press, the publication agent of The Johns Hopkins University. Later Charles K. Clarke, of Toronto, was added to the board to represent Canada. For seven years the managing editor of the *Journal* was Dr. Henry M. Hurd, but he retired in 1904, and Dr. E. N. Brush assumed the duties and has continued managing editor until the present time.

During the past 25 years a notable change has taken place in the contents of the *Journal*. The large number of semi-popular papers which formerly appeared in its pages has given place to articles of a more scientific type, such as descriptions of forms of mental disease, descriptions of pathological processes, and valuable contributions to the pathology of insanity. The *Journal* has never been a source of income to the Association and in fact has been published at a small annual financial loss. It has, however, exercised an important influence in consolidating public opinion throughout the entire profession of mental medicine, and has thus wielded a decided influence in matters of public policy. In reviewing the pages of the *Journal of Insanity* during its existence of nearly 70 years one is impressed with the extent and variety of the

material appearing therein, and the influence which it had upon the growth and development of an enlightened sentiment in behalf of the insane in the United States. It is possible to trace in its pages the distinct trend of important currents of public opinion which have developed from time to time throughout the country. In the early history of the *Journal* its pages were mainly occupied with considerations of mental disease and its treatment. An endeavor in fact was made by the first editor, Dr. Brigham, to gather as much material as possible from every quarter in reference to insanity. He collected and printed, for example, the descriptions of insanity contained in the plays of Shakespeare and the works of other poets; and gathered statistics as to the existence and extent of mental disease in foreign countries. The incidence of suicide throughout the country was carefully considered and an effort was made to gather adequate statistics from every state. The best methods of caring for patients were studied as also the best organization of institutions for the insane. It was evidently the intention of the editor to make the *Journal of Insanity* a popular journal to diffuse knowledge about the insane throughout the entire country, with special reference to the instruction of the medical profession. In the five volumes edited by Dr. Brigham it is of interest to note the extent and variety of his personal communications to the *Journal*. He reviewed the reports of institutions; gathered interesting items about insanity from literature, current publications and text-books; corresponded with his professional associates in reference to mooted points in psychiatry, and when absent from home visited institutions for the insane and described them. Even when journeying in search of health he sought out such institutions, both public and private, in various states from New York to Mexico, and in his letters gave many acute and valuable criticisms upon their condition. It is evident that he was not so much a profound student of mental disease as one interested in the social and humane aspects of insanity. Had he lived it is probable that the *Journal* would have retained its semi-popular character and may have remained in closer touch with the medical profession of the United States.

The present Board of Editors is composed of G. Alder Blumer, Edward N. Brush, Charles K. Clarke, Henry M. Hurd and J. Montgomery Mosher. Edward N. Brush has been for ten years managing editor.

CHAPTER II

EARLY LEGISLATION FOR THE INSANE

I.

EARLY AND COLONIAL CARE OF THE INSANE.

To all who have considered the intimate relations of insanity and pauperism, especially under the conditions of pioneer life, where no machinery had yet been established to enable the state to carry out its obligations to the dependent classes, it will not appear strange that few references to the dependent insane occur in the early laws of the colonies. There is reason to believe in fact, that little legislation existed on the subject, and that most of the records that pertain to it have been lost.

In subsequent chapters the early care of the insane in the older colonies and states has been gone into somewhat in detail. It has been thought wise, however, to give in the following pages a brief account of the early efforts in behalf of the insane as regards the colonies at large.

In New England it is probable that the care of the insane, owing to the complexity of township organization, devolved upon the townships or the town councils of the different villages and towns, and that insane persons only came to the notice of the public authorities when they were indigent and needed charitable assistance. Where they were members of wealthy families, who were able to secure personal care and nursing for them, little thought seems to have been given to their existence. The dependent insane were classed as paupers, but were regarded as special objects of charity.

When we remember the conditions of comparative poverty in which the early colonists lived, it is not surprising that special precaution should be taken lest wandering individuals, destitute of any claim upon public charity, might gain a residence which would give rise to future trouble by their dependent condition. It is in this regard that we find in 1639 the first reference to any law of settlement in Massachusetts, when the power to determine the settlement of any person requiring public relief was given to the general court, or to any two magistrates out of court. In 1645, it is

stated that " Mr. Shepheard, John Johnston and Captain Wiggin " were chosen a committee to consider the law " for disposing of inmates and settling impotent (feeble mentally?) aged persons or vagrants." Again in 1655 each town was authorized to " refuse admission to persons from other towns in the colony." All persons were to be considered town charges and no one was to receive aid directly from the general treasury of the colony. It was also enacted that " three months' quiet, undisputed residence gave a settlement."

The earliest record of any legislation regarding the insane in Massachusetts is a law, passed in 1676, which delegates to the selectmen the care of the person and estate of the dependent insane.

In 1694, in " An Act for the Relief of Idiots and Distracted Persons," the care of the insane is given to the selectmen and overseer of the poor, but the disposition of their property is given to the justice of the peace.

In 1736 the first reference to methods of determining the insanity of the individual is found in a law giving power to the judge of probate, on the request of friends or the overseers of the poor, to direct the selectmen to make inquisition, the final decision, however, seeming to depend upon the opinion of the selectmen or overseers of the poor and the judge.

In 1784 an act was passed in regard to guardianship of the insane, and in 1798 a law which permitted such lunatics as were " furiously mad, so as to render it dangerous to the safety or the peace of the good people to be at large," to be committed to the House of Correction.

The next legislation is found in 1811, when the Massachusetts General Hospital was incorporated and the McLean Hospital was established, it being subsequently opened in 1818.

Despite the fact that the early settlers of Rhode Island were very poor, one of the earliest records as regards the insane, which is quoted in full elsewhere,[1] is from Rhode Island, dated November 11, 1650, and contains a touching appeal to the Town Council of Providence from that stern Puritan, Roger Williams, on behalf of a Mrs. Wilson, whom he describes as a " distracted woman " and for whom he urges them to make provision, " remembering," he concludes, " that we know not how soon we ourselves may be

[1] Care of the Insane in Rhode Island, Vol. III.

deprived of our reason—except mercy from ye God of Mercies prevent it."

A little more than a year later, there is a record of an order authorizing the town council to take charge of the person and property of one Margaret Goodwin, " during her distraction," and requiring it to account for its disposition of her estate.

During the next 50 years records of similar orders are to be found at intervals.

In 1725, the first law was passed for the care of the insane, by which the inland towns were empowered to build houses of correction for vagrants, " and to keep mad persons." In 1742 a law was passed giving to the town council the care of all insane and imbecile persons, with power to appoint guardians for their estates.

In 1828 the Dexter Hospital was opened, and gave accommodation to a small number of insane from Providence exclusively. On December 1, 1847, the " Butler Asylum for the Insane " was opened.

In Connecticut the town system of relief for the poor was almost universal and aid was dispensed by the selectmen of the towns, as these officials were familiar with the actual home conditions of those who required public support.

The first record of public relief for the insane in Connecticut is to be found in the records of the Colony of New Haven for 1645, where a patient is stated to have been partially relieved in her home. In 1648 an additional record is made that the same person had been cared for in the home of the marshal, who asked to be relieved of her care.

In 1655 was passed the first law of settlement of paupers, which undoubtedly included the insane, although they were not so specified until later. In 1673 the general court ordered each town to care for its own poor, but provided that a town might escape the responsibility of strangers by warning them to depart within three months of their arrival.

In 1699 the General Court of Connecticut passed " An act for relieving idiots and distracted persons," which copied verbatim the provisions of the Massachusetts law of 1694. In 1711 another law was passed entitled " An act to provide in case of sickness, including insanity, feeble-mindedness and similar conditions."

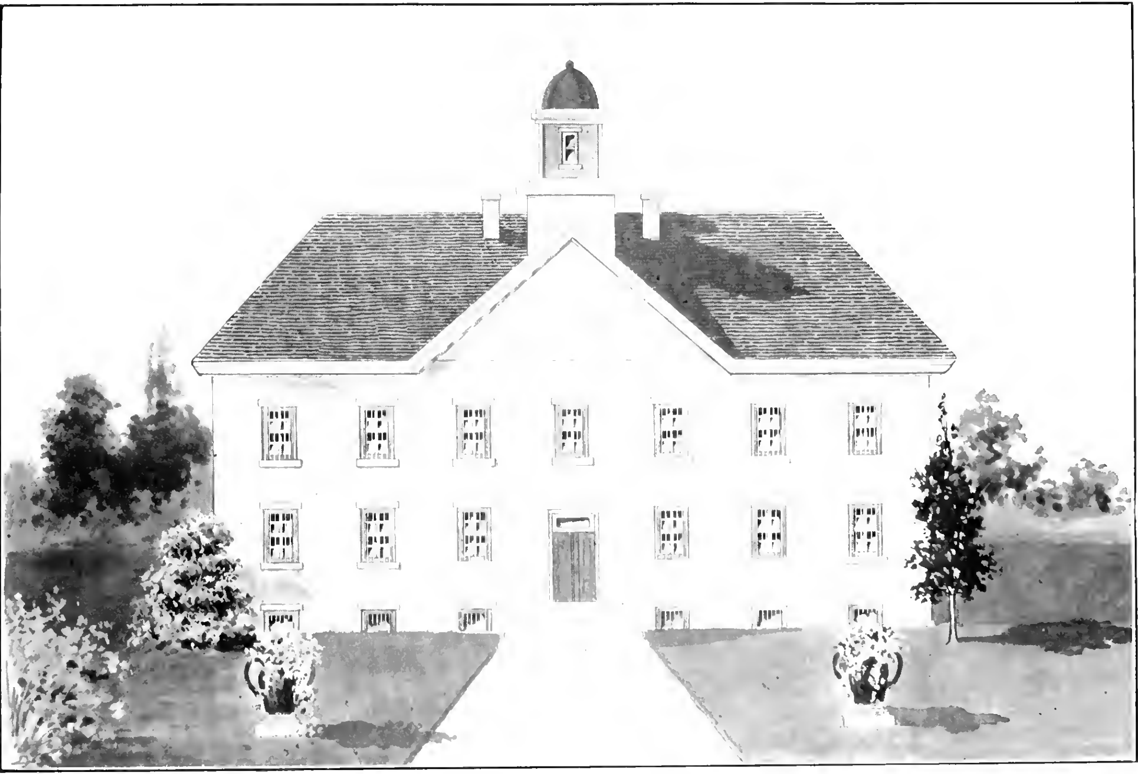
In 1727 the number of disorderly persons in Connecticut had become so large that a colony workhouse was built to which all disturbers of the public peace were to be committed, as well as " persons under distraction and unfit to go at large, whose friends do not care for their safe settlement."

In 1715 a law had been passed providing that the relations of the insane, within certain specified degrees of consanguinity, should assume the duty of providing for them, a fine of 20 shillings being imposed for failure to comply with this requirement, the money to be applied to the support of the insane relative in question. This law was amended in 1739, 1745, 1750 and 1784, all the amendments being directed more to the protection of property belonging to the insane than to their personal safety and comfort.

In 1793 a law was passed by which it became the duty of the county authorities and selectmen of the town of residence to order a dangerous insane person to be confined in a suitable place, the county jail if necessary. At the same time the authority to commit an insane person to the workhouse was repealed. In 1797 the section concerning the confinement in jail was also revoked.

In 1824 a law was passed whereby any citizen could complain to one of the civil authorities, or to the selectmen in his town, if he found an insane person at large. If within three days no action was taken under the statute he might complain under oath to any justice of the peace, and inform him that the person was dangerous and unfit to be at large. It was then the duty of the justice of the peace to have the said person brought before him, or some other justice of the peace, and if, upon inquiry, the complaint was found to be true, he was empowered to order the person to be confined in a suitable place as long as it was deemed necessary. If satisfied at any time that the person was no longer dangerous to go at large, he might order his discharge. These provisions did not apply to the harmless insane; care for their safety did not come until later.

In the period between 1793 and the founding of the Hartford Retreat in 1824 there was no public place in which harmless insane persons, not criminals, might be confined. Capen says, " it is hardly necessary perhaps to imagine how these unfortunates were cared for before the days of the improved modern asylum, but it may be mentioned in passing that in a memorial presented to



EASTERN LUNATIC ASYLUM, WILLIAMSBURG, VA., ABOUT 1774.

the Assembly in 1786, Mary Weed, of Stratford, stated that for 20 years her husband had been so insane as to be kept "chained."

No records are available as to the care of the insane in Vermont, prior to the establishment, in 1834, of the Vermont Asylum for the Insane, now the Brattleboro Retreat.

The first record in New Hampshire as regards legislation for the insane occurs in an act passed in 1714 by the colonial legislature of New Hampshire for the "Relief of Idiots and Distracted Persons."[1] This act is similar to those passed by other states, and empowered the overseers of the poor of the town where the insane person was born, or was by law an inhabitant, to make necessary provisions for "the relief, support, and safety of such impotent or distracted persons at the charge of the town or place whereto he or she of right belongs." In one respect the act differs from others of similar nature. It gave to the justices of the peace the power to put such insane persons to any work or service of which they may be capable, at the discretion of the selectmen and overseers of the poor.

This act constituted the sole legislation in behalf of the mentally diseased until 1767, when an act was passed entitled "An Act in further addition to an Act entitled 'An Act for the Relief of Idiots and Distracted Persons.'" This act empowered the judge for the probate of wills and for granting letters of administration, upon request of some relative, friend of any "idiot, non compos lunitick or distracted person, or the overseers of the poor where the said idiot or distracted person" lived, to make inquiry into the condition of the person in question, and to appoint a suitable guardian to take charge of the patient's property.

The judge was further empowered to make inquiry in case anyone was suspected of embezzling or making illegal disposition of the property of a mental defective, and if the person so accused be found guilty, to commit him to prison.

The acts of 1776 and 1791 are merely résumés of the previous acts.

In 1822 a further act was passed,[2] and in 1830 a movement was begun for the building of a state asylum. After many delays this effort proved successful and resulted in the opening on October 29, 1842, of the New Hampshire Asylum for the Insane, at Concord.

[1] See Care of the Insane in New Hampshire, Vol. II.

[2] See Care of the Insane in New Hampshire, Vol. II.

In New York there seems to have been very little early legislation in reference to the insane, and they were probably, if dependent, classed among the poor.

In October, 1665, an amendment to the Duke of York's laws provided that as distracted persons may be very chargeable and troublesome, and so prove too great a burden for one town to bear, that therefore, each town in the "rideing" where such persons happen to be shall contribute towards the charges which may arise on account of such persons.

In 1736 a building known as the "Publick Workhouse and House of Correction of the City of New York" was built, and in it the insane were confined.

According to Mosher, the first statute in existence regarding the insane is a law passed in 1788, under the title "An Act for Apprehending and Punishing Disorderly Persons." This act provided:

> Whereas there are persons who by lunacy or otherwise are furiously mad and so disordered in their senses as to be dangerous to go abroad, it shall be lawful for two or more justices of the peace to cause to be apprehended and kept safely locked up, such persons in some secure place, and if necessary to be chained there, if the place of their legal settlement be in the city or town within that county.

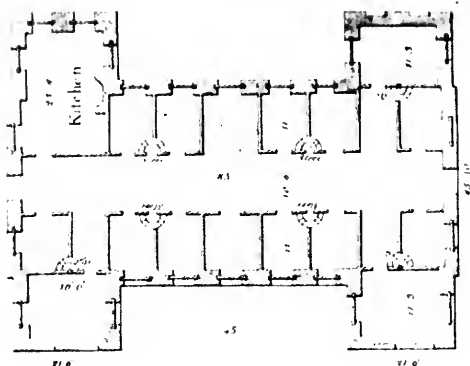
In May, 1797, the admission of two cases of mania is noted in the records of the hospital in the City of New York now known as New York Hospital.

In 1806 the hospital in the City of New York was authorized by statute to enlarge the same by erecting additions for the more convenient accommodations of the sick, and particularly to provide suitable apartments for maniacs, adapted to the various forms and degrees of insanity.

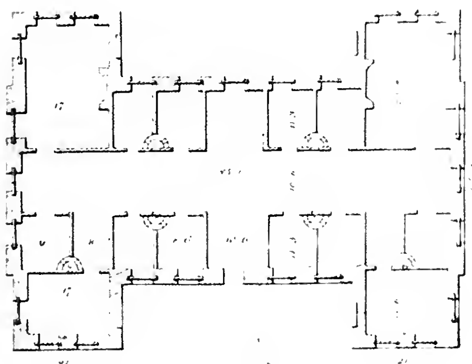
In 1827 an act was passed providing that "A lunatic shall not be confined in any prison, jail or house of correction, or confined in the same room with any person charged with or convicted of any criminal offense." In the revised statute of 1827 and 1828, it was made the duty of the overseer of the poor of the city or town where a lunatic was found, to apply to any two justices of the peace of that city or town, who, if they were satisfied that it was dangerous to permit the said lunatic to go at large, were required to issue their warrant, directed to the constable and overseer of the poor, commanding that they cause him to be locked up and con-

NEW YORK HOSPITAL (LUNATIC ASYLUM), 1806-1821.

Sub Basement



ASYLUM



Principal Story

LUNATIC ASYLUM—GROUND PLAN OF BUILDING TO THE LEFT OF GENERAL HOSPITAL

fined in some secure place, to be provided by the overseer of the poor.

In 1838 county poorhouses and private and public county asylums and the lunatic asylums in the City of New York were all recognized by legislative enactment, but it is apparent that the care of the insane was not recognized as a public duty, except in so far as it was deemed desirable to protect the public from the dangerous tendencies of lunatics running at large, or to guard the unfortunate individual himself from the consequences of his mental irresponsibility. It was not until 1842 that laws were passed to erect the first state institution for the insane in New York.

There is no record of any provision for the insane in New Jersey prior to a letter, dated July 29, 1772, from the Lords Commission of Trade and Plantations in London, to Sir William Campbell, Governor of Nova Scotia, submitting the draught of a clause it was proposed to insert into the king's instructions to all governors in America, giving them, as chancellors, the power to issue commissions for the care and custody of idiots and lunatics. This clause appears to have been submitted to William Franklin, a son of Benjamin Franklin, at that time Governor of New Jersey, and it, together with his reply, dated October 12, 1772, is quoted in full in the chapter on the Care of the Insane in New Jersey.[1]

On November 21, 1794, the Legislature of New Jersey passed an act entitled "An Act for Supporting Idiots and Lunatics and Preserving Their Estates."[2] This act, as well as the succeeding one of 1804, was more concerned with the care of the property of the insane than the care of their persons. Again in 1818 we find a new act, providing in one section that idiots and lunatics shall not be arrested or detained in custody as criminals, and in another provision for the apprehension and locking up, chaining if necessary, of "any lunatic furiously mad, or dangerous to go at large."

It was not until 1838 that the need of an asylum for the exclusive care of the insane began to be felt. The agitation beginning from an address by Dr. L. A. Smith, delivered before the State Medical Association in New Brunswick in May, 1836, finally resulted, with the assistance of Miss Dix, in the passage on March 20, 1845, of an act entitled "An Act to Authorize the Establishment of the New

[1] See "The Care of the Insane in New Jersey" in a subsequent volume.
[2] *Ibid.*

Jersey State Lunatic Asylum." On May 25, 1848, the asylum was opened for the admission of patients.

In 1676, in the records of the Upland Court, Delaware County, occurs the first mention of any provision for the insane in Pennsylvania. It concerns "Erick," son of "Jan Vornelissen," who "is turned quyt madd," and provides that a "small block-house" be built for him and a "levy be laid" to pay cost of same, and for his maintenance, "according to laws of ye government."[1]

The "Religious Society of Friends," at one of their monthly meetings in 1709, took steps for the establishment of a hospital for the sick and insane. This ultimately resulted in the founding of the Pennsylvania Hospital in 1751. Prior to that time the insane people were cared for in an almshouse in the vicinity of Philadelphia, known as "Green Meadows." In the petition to the Assembly of 1751, drafted by Benjamin Franklin, asking for an appropriation to defray the cost of establishing the Pennsylvania Hospital, the desirability of protecting insane persons is expressly alleged as one of the reasons for building such a hospital. A portion of the Pennsylvania Hospital was set apart for the insane, and two insane patients were admitted in 1752. The records of the hospital contain an interesting record left by one of the trustees, of his impressions of the patients confined in the cells, many of them for long periods of years.

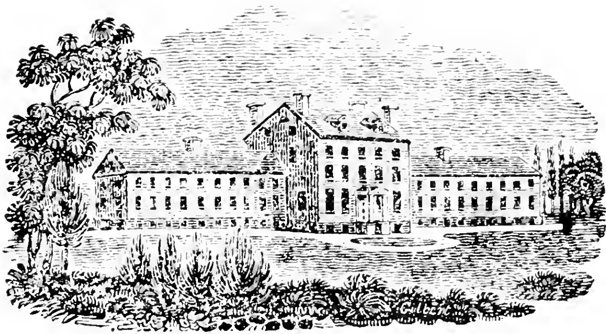
In 1803 it seems to have been thought that the insane who were transferred from the almshouse to the Pennsylvania Hospital could be made as comfortable in the almshouse, and a record is found of their being removed to the successor of the almshouse mentioned above as "Green Meadows," and which was then located at Tenth and Pine streets.

In the following year there is record of the erection of apartments for the treatment of the insane at the almshouse.

In 1817, in consequence of an agitation begun in 1811, the Society of Friends opened at Frankford an institution for the care of such of their members "as may be deprived of their reason." This is now the Frankford Retreat, a full history of which is given in a subsequent chapter. In 1836 all sectarian restrictions as to admission therein were withdrawn.

From 1830 to 1834 the Blockley Almshouse seems to have been regarded as the proper place for the treatment of the dependent

[1] Care of the Insane in Pennsylvania.



FRIENDS' ASYLUM, 1818.

insane in the vicinity of Philadelphia, and one of the buildings belonging to the group designed for disorderly persons was appropriated to their care. About the year 1850, however, a separate building was erected for the insane, provided with cells and all the old time apparatus for the care of such patients. These cells were finally removed about the year 1860.

In Delaware the earliest legislation in regard to the insane is an act of February 2, 1793, which vests in the court of chancery the care of all idiots and insane over the age of 21. No provision is made for their care, and no doubt the same condition prior to that date continued whereby each family cared for its own insane, unless they became unmanageable, in which case they were sent to the nearest county jail.

In 1812 a further act was passed giving to the court of levy in each county the power to remove all idiots and insane from the county jail to their respective poor houses.

The counties continued to care for the mentally defective up to 1889. On April 25 of that year the legislature passed an act, by virtue of which the state assumed complete charge of all insane and mentally defective persons. Delaware thus became the first state in the Union to establish state care.

In Maryland the custody of the pauper insane and relief of the poor belonged to the vestries of the established church, which was the Church of England. After the Revolution of 1776, and the consequent dissolution of the relations between the parish vestries and the state, the duty of such relief was committed to newly established boards of overseers of the poor, which, being no longer coterminous with the parish, became officials of the whole county.

An examination of the Acts of the Assembly of Maryland reveals the fact that about 1773, poorhouses, almshouses or workhouses were established in four counties of the state, under the supervision of directors of the poor. These poorhouses were designed for the poor and needy, who required charitable attention and support, and also for the idle, the vicious, the dissolute, and the disorderly, but there were, no doubt, many instances where insane people, incapable of much self-control, were regarded as disorderly.

In the Acts of the Assembly of 1791 we find that the justices of Prince George County were authorized to levy a tax for the main-

tenance and keeping of Mary Brown and her daughter, Eleanor Love. The laws of 1793 contain a petition of Juliana Fowler for the support of her daughter, who was "deprived of the use of her reason." In these and numerous similar petitions of the same period, the reason given for seeking assistance is always the same, namely, the desire to avoid sending an insane relative to the county poorhouse, against which there was evidently a strong prejudice.

The first act providing for a state institution for the insane was passed on January 20, 1797.[1] It resulted, with the help of the City of Baltimore and of private citizens, in the erection of a "Lunatic and General Asylum," built on a plot of ground that now composes part of the site of The Johns Hopkins Hospital. In 1808 the hospital was leased by Drs. James Smythe and Colin Mackenzie, and was used by them and their successors for the care of the insane as well as of general patients. At various times the legislature made appropriations for its improvement, and in 1834 the state asserted its right to the hospital, and by legislative enactment devoted it to the exclusive use of the insane.

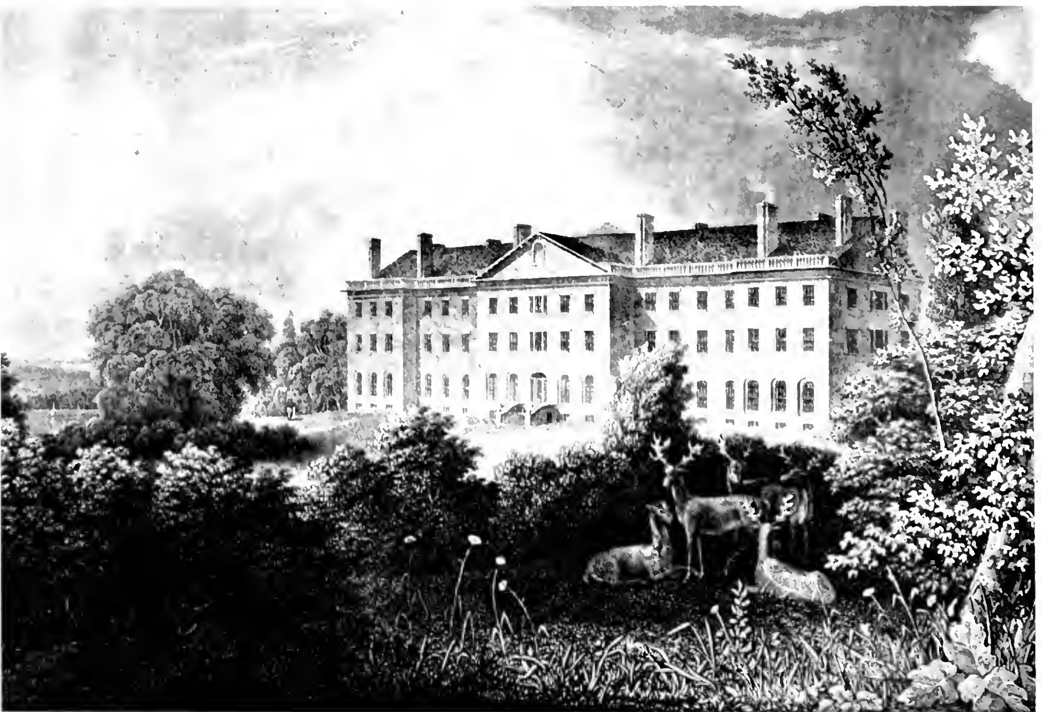
The successor of the hospital is now known as Spring Grove State Hospital, located at Catonsville, about seven miles from Baltimore.

In Virginia, as in Maryland, the custody of the pauper insane and the relief of the poor belonged to the vestries of the established church, which was the Church of England, until the Revolution of 1776 dissolved the relation between church and state.

To Virginia, however, belongs the honor of providing the first state hospital in America, used exclusively for the insane. This was "The Public Hospital for Persons of Insane and Disordered Minds," now the Eastern State Hospital at Williamsburg. It was incorporated in 1768. In 1769 the House of Burgesses passed an act "To make provisions for the support, and maintenance of idiots, lunatics and other persons of unsound mind."[2] This act appointed trustees, and made provision for the building and maintenance of the hospital, as well as rules for the admission of patients. A building was accordingly built, and the first patients admitted in October, 1773. We find in the records further laws pertaining to the hospital during the years between 1776 and 1790.

[1] See Care of the Insane in Maryland.

[2] See Care of the Insane in Virginia.



BLOOMINGDALE ASYLUM, 1821.

This hospital was also the first in the country to care for the colored insane.

On January 22, 1825, the legislature passed an act providing for the erection of another hospital to be built west of the Blue Ridge. This institution was opened on July 25, 1828, and is now known as the Western State Hospital for the Insane, at Staunton, Va.

There are apparently no records available as to the early care of the insane in North Carolina prior to the visit of Miss Dix, which resulted in an act of the Legislature of 1849, establishing a state hospital at Dix Hill, near Raleigh, named in honor of Miss Dix.

According to Babcock, the public charity of South Carolina dates from the permanent settlement of Charleston, and had for its basis the "Poor laws of England." Acts for the maintenance of the poor are found in 1722, 1737, 1738 and 1751. One of the most interesting sections of the act of 1751 provided for subsistence of slaves, who may become "lunaticks" while belonging to persons too poor to care for them. This appears to be the earliest legal recognition of the insane in South Carolina.

"The Fellowship Society of Charles Town,"[1] established in 1762 and incorporated in 1769, had for its object the founding of an infirmary "for the reception of lunatics and other distempered persons in the province." There is no record, however, that the hospital was ever built.

In 1808 judges of the Court of Common Pleas were vested with the same power as courts of equity, to inquire into cases of lunacy or idiocy, and to appoint guardians for them. According to Mills there seems to have been a poorhouse and asylum (for lunatic persons) situated at the corner of Queen and Mazyck streets, which had been founded at a very early period.

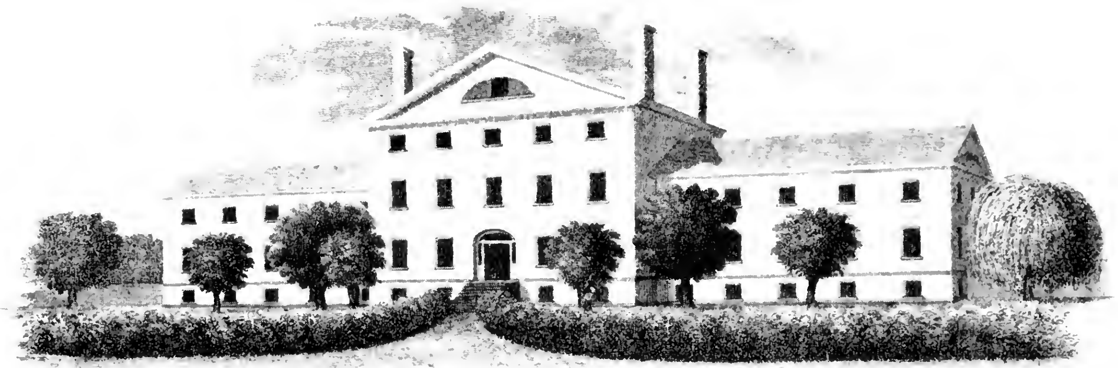
On December 21, 1821, the General Assembly passed an act authorizing the erection of a lunatic asylum to be combined with a school for the deaf and dumb. This resulted in the erection of the present State Hospital of South Carolina, which was opened for the admission of patients in December, 1828.

There are apparently no available records as to the care of the insane in Georgia prior to a paragraph in the annual message of Governor Wilson Lumpkin to the Georgia Legislature on

[1] Now known as Charleston, S. C.

November 4, 1834. No action was taken until 1837, in which year the legislature made an appropriation for building an asylum. This asylum was opened for the admission of patients in December, 1842, and is now known as the Georgia State Sanitarium at Milledgeville.

This comprises the history of the early care of the insane in the 13 original colonies. The histories of the care of the insane in the newer states will be found in subsequent volumes dealing with the different states in detail.



HARTFORD RETREAT, 1824.

II.

THE ERA OF AWAKENING.

The era of awakening came slowly in the United States. As has been stated in a previous chapter,[1] the insane and dependent classes became early identified with each other. In many Eastern states the only insane cared for were those already paupers and frequently, as in New Hampshire and Connecticut, those that were feeble and helpless, were bid off each year by persons who were prepared to assume charge of them at the lowest figure. In consequence they were placed in such poor and unsuitable homes as would naturally be furnished to them by persons who were willing to eke out a small income by the care of an insane person in the family. Most of those who were able to look after themselves were allowed to wander about through the country, exposed to hardships, danger and ill-treatment. If they were violent or destructive they were cared for in cages or pens in county houses or were placed in jail. No systematic effort was made to assume care of any of these patients at a stage of their disease when they were in a condition to receive benefit from treatment; they were neglected until incurable and when incurable were taken care of in the cheapest manner possible without regard to their comfort and well-being. This condition of affairs existed throughout the United States and no state unfortunately can claim the monopoly of ill-treating the insane.

The effort made in Philadelphia in connection with the Pennsylvania Hospital for the Insane in 1751, and the establishment of the institution at Williamsburg, Va., in 1773, while steps in the right direction, cannot be considered as affording, at first, any measure of relief in the way of medical treatment. The term insane referred at that time more especially to such persons as were violent and required custody to prevent them from doing injurious acts toward their neighbors or themselves.

At Williamsburg the medical care was confined to a non-resident physician who visited the institution but did not have the respon-

[1] Early and Colonial Care, page 81.

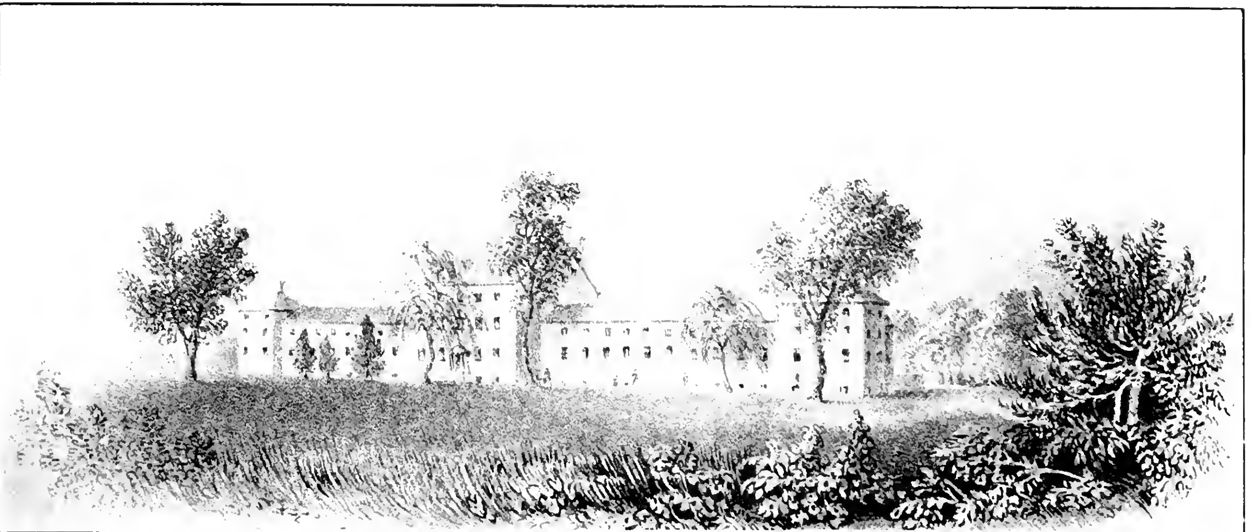
sibility of its management. This was committed to a keeper. At the Pennsylvania Hospital the care of the insane was almost wholly custodial and for a long time, and probably until the time of Rush, little was attempted in the way of medical treatment.

The department for the insane connected with the New York Hospital, afterwards known as the Bloomingdale Asylum, and now as the Bloomingdale Hospital, although housed in a separate building in the upper part of the city in 1821, could do little for the care of the indigent insane, although authorized by law to receive such patients; the cost of treatment was necessarily so high that county officials were disinclined to make contracts with it for the care of their insane and preferred to neglect them at home.

A similar condition existed in regards to McLean Hospital, which was founded in 1818 as a department of the Massachusetts General Hospital, but subsequently, through the liberality of John McLean, erected upon a separate estate, and thus enabled to lead an independent existence. It did not, however, materially ameliorate the condition of the dependent insane.

So also the Friends' Asylum established at Frankford, a suburb of Philadelphia, which, although it did excellent work in a quiet, unostentatious way, provided for members of the Society of Friends only, until 1834.

In Connecticut, however, owing to the efforts of the State Medical Society, a different condition prevailed. Through its efforts funds were furnished for the establishment of the Hartford Retreat. This institution was of a semi-private class, but also had an arrangement with the towns of Connecticut and received indigent patients at a rate of payment less than the actual cost of treatment. It fortunately came under the guidance of Dr. Eli Todd, who became its first superintendent, and seems to have had a general interest in the better treatment of the insane throughout the New England states. The building of the Hartford Retreat directly influenced the establishment and building of the institution at Brattleboro, Vt.; it also had much to do with the establishment of the State Asylum under Dr. Woodward, at Worcester, Mass., and to a less degree with the establishment of the Boston City Hospital for the Insane. The work in New Hampshire was connected closely with the establishment of the Brattleboro Retreat. The slow growth of public sentiment in the state is shown by the strug-



FRIENDS' ASYLUM, FRANKFORD, PA., 1828.

gle in New Hampshire prior to the erection of the New Hampshire State Hospital. It took 11 years of continuous agitation before an institution was established at Concord. Even when established it was not a state institution, although it received state aid. Had it not been for the benefactions of benevolent friends it is doubtful whether it could have attained the degree of usefulness which afterwards came to it. In fact only within the past decade has the movement been concluded, which began in New Hampshire more than 70 years ago, to provide state care for the indigent insane.

The Eastern Lunatic Asylum, now the Eastern State Hospital, Lexington, Ky., was opened as a state institution, May, 1824. This was the second state institution to be established in the United States, Williamsburg being the first. On July 25, 1828, Virginia provided a second state institution for the care of her insane, when the Western State Hospital was opened at Staunton. On December 12, of the same year, the South Carolina Hospital at Columbia was opened, having been built by the state after a long and determined effort on the part of two philanthropists who were not medical men. The institution was designed for all classes of patients who paid their expenses or whose expenses were paid by the counties. It was not a state institution as we understand it to-day.

The three institutions just mentioned grew out of the success of the institution at Williamsburg, while the New York Hospital and McLean Hospital were largely the result of the good work inaugurated in the Pennsylvania Hospital.

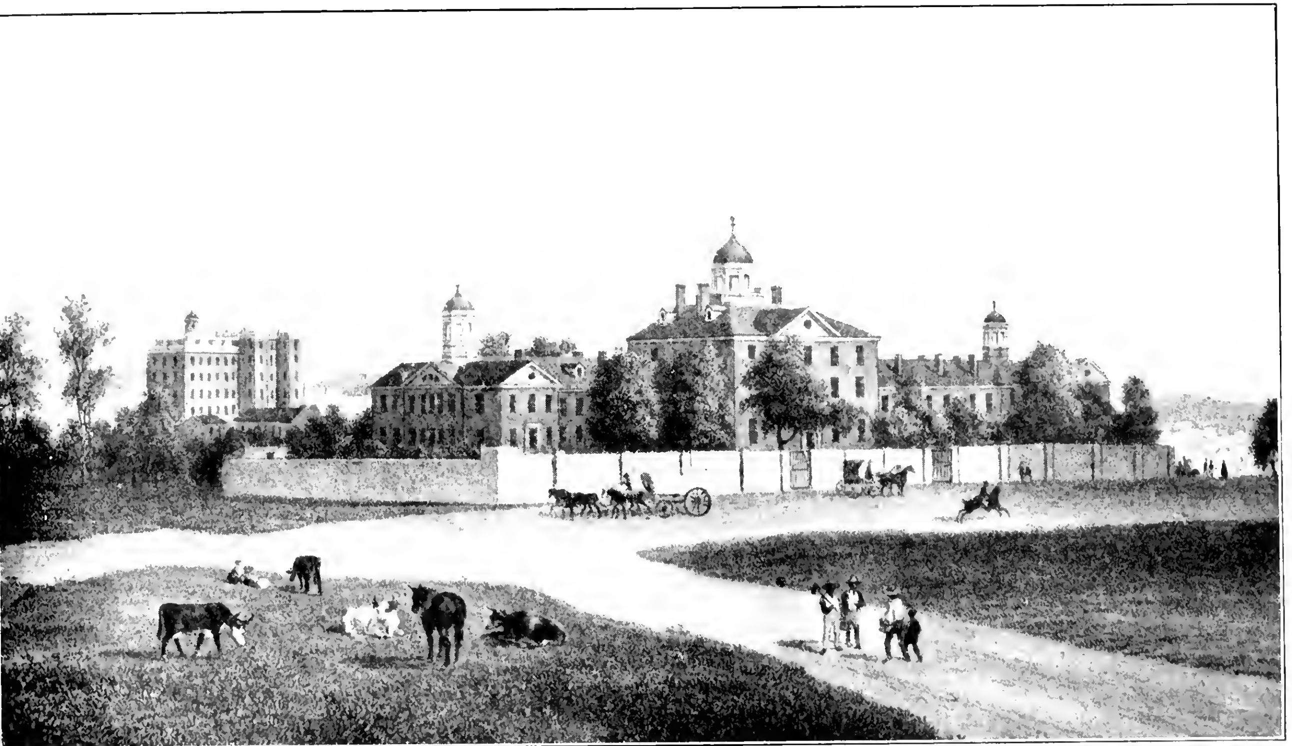
The Friends' Asylum and the Hartford Retreat were both important factors in the erection and organization of the Utica State Hospital on broad lines. The commission charged with its construction and later with the duty of devising rules for its organization and management, although it had visited the institutions for the insane then existing in this country, based its recommendations largely upon the experience of the Friends' Asylum and the Hartford Retreat.

The organization of the Utica State Hospital had probably as much to do with the progress of the movement as any other single agency. Here we had an institution built by a state on an extensive and liberal scale, officered by meritorious appointment of officers, with definite laws for the admission and discharge of patients. The definite object of the institution was to take the insane out of

almshouses and to provide for them in a well ordered hospital. Here also for the first time under state charge was provided some accommodation for private patients of the semi-indigent class. The act under which the Utica Hospital was organized has been a model for similar institutions throughout the United States, and has undoubtedly proven an important agency in developing state care.

The era of awakening came like a popular wave in various states and resulted in the establishment of institutions in many New England, Middle and Southern states.

We now know that many of the views which were generally entertained and promulgated at that time were erroneous, and that mental disease was a much more serious constitutional disorder than any person realized. An excellent beginning, however, had been made and valuable work was accomplished in calling the attention of the different states to the needs of the insane. Several states had a single state institution, or one or more corporate hospitals for the care of acute and presumably curable cases of insanity. This provision, even in favored states where an institution had been established, proved wholly inadequate. In a few years many patients had already passed through the institution and, after receiving several months of treatment, had been returned as incurable to their friends, or to almhouses or houses of correction. The wave of enthusiasm which accompanied the original establishment of a hospital for the insane had spent itself in many states, and the insane, with the exception of comparatively few persons who remained under treatment in the newly established institutions, found themselves very much as they had been prior to hospital provision. Unquestionably the standard of care for the insane had been raised, and the hopes of friends and relatives had been stimulated to such a degree that they were no longer satisfied to have those in whom they were interested again neglected and abused. It is evident, however, that the country as a whole had not become aroused to the needs of the insane, that the majority of the states were destitute of special provision for their care, and that no state had provided sufficient institutions for their treatment. How long this condition might have continued cannot be predicted; it is evident, however, that a mighty influence in the person of Miss Dix, a woman of strength, of purpose, vigor



MARYLAND HOSPITAL FOR THE INSANE, 1832.

of mind and unusual activity, was an important factor in extending the work which had already hopefully begun in a half-dozen states. All concede that the labors of this remarkable woman contributed more to the general awakening of the country to the needs of the insane than all other agencies combined. Her labors during the next 40 years resulted in the establishment of nearly as many institutions for the insane in the United States and Canada, and also accomplished much in the same cause in England and upon the continent. It has been said that in the onward march of civilization the influence of men of ability and genius must always be regarded as controlling factors in its immediate progress. The influence of Miss Dix was unquestionably of this character, and without doubt her labors advanced the general care of the insane in America fully a quarter of a century.

CHAPTER III

PHILANTHROPIC WORK OF MISS DIX

I.

DOROTHEA LYNDE DIX AND HER WORK.[1]

All important crises in historical movements are associated with the lives and conduct of marked individuals; persons who have advanced some original or discriminating conception as to duty or public policy, and who, through enthusiasm, strength of purpose and the force of personality, have initiated and conducted to a successful issue a notable departure in government, moral and religious convictions, social habits, or institutional methods.

The history of insanity, in conformity with this universal law, has its conspicuous pioneers, its epoch-making masters, its heroes and heroines. In this connection many American specialists are entitled to more or less prominence. But from the standpoint of personal labors to promote practical reforms in public provision for the insane, the work of Dorothea L. Dix stands pre-eminent.

Her surroundings in childhood were humble and she had a hard struggle to obtain an education, followed by a toilsome period spent in school-teaching. But in spite of these difficulties in her early life and of the semi-invalidism which, later on, hampered her physical activity, she achieved a national and even an international reputation as a practical philanthropist, her remarkable personal influence over public officials and governmental policies contributing greatly to her success. In the 40 years of her public work she was instrumental in founding or enlarging more than 30 state institutions for the proper custody and right treatment of the insane,[2] becoming an acknowledged power in this respect not only throughout the United States, but in European countries as well. It is impossible to estimate how many men and women, suffering from mental disease, she extricated or preserved from public jails and private pens, or how many others enjoyed release or exemption from galling chains and other cruel devices for restraint as a result of her humanitarian efforts.

[1] The material for this chapter has been mainly gathered from a more elaborate paper now in preparation for separate publication by Dr. C. W. Page, of Hartford.

[2] Tiffany, p. 361.

Dorothea Lynde Dix was born April 2, 1802, at Hampton, Me., where her parents were temporarily located. Her father, Joseph Dix, was descended from good Puritan stock, which for generations had maintained its stamina in New England. He himself, however, seems to have been lacking in mental balance and unable to maintain his wife and three children suitably. Having no established business occupation he repeatedly changed his residence. His legal domicile was Worcester, Mass., but for short periods he endeavored to make a living in Maine, New Hampshire and Vermont. In religious matters his zeal outran his discretion, and at times his spirtual fervor led him to compose, publish and distribute fanatical tracts. In her childish days the little Dorothea was often called upon to paste and stitch these unprofitable leaflets. The mother evidently lacked force of character sufficient to counterbalance her husband's weak judgment, or even to command the respect of her eldest child.

Under such family circumstances, deprived of the care and attention, the material comforts and the agreeable associations requisite to satisfy normal childish longings, the bright, sensitive, proud-spirited Dorothea suffered grievously. In after years she once made the pathetic avowal, "I never knew childhood."

When she was 12 years of age, her native good sense and awakening ambition asserted themselves. She refused to contribute further aid to her father's tract-making schemes and repaired to her grandmother's house in Boston, where she was sure of a welcome and had the advantages of a superior home, good schools, association with cultured people and a loving intimacy with her grandmother, a dignified and circumspect, but kind and judicious woman, so commonly found among Puritan families in New England. Her grandfather, a physician and chemist, was a well-known man, long remembered for his strong character and unique personality. He was industrious, thrifty, fertile in resource and scrupulously honest. Endowed with clear, far-sighted judgment, unusual energy and conspicuous courage, he often originated new and startling propositions in business, both public and private. In fact, his confidence in his own wisdom and conscientious intentions made him at times somewhat aggressive in matters of public interest. Dorothea seems to have inherited many of his prominent traits. Unfortunately his death, when she

was seven years of age, deprived her of his affection and counsel in her struggle for a position of independence and influence.

Dorothea, after two years with her grandmother in Boston, occupied in diligent study, returned to Worcester to open a school for children. This first school was a moderate success. She was a faithful and earnest teacher, but an exacting disciplinarian. The school proved to be short-lived, and was discontinued after a few months. With added experience and a better comprehension of her own educational limitations, Dorothea determined to fit herself to teach older pupils and to give higher courses of instruction. With this intention she returned to Boston, where she studied industriously and read much in general literature, until in 1821, at the age of 19 years, she considered herself competent to teach young ladies and opened a day school in Boston.

She not only wished to gain personal independence for herself, but also to support and educate her two brothers. The small house in which the school was opened soon became overcrowded and was exchanged for her grandmother's residence, known as the "Dix Mansion." The high reputation which the school acquired attracted pupils from prominent families in Boston and elsewhere throughout New England. With the rapid development of her school, Miss Dix gradually assumed many arduous duties: she managed the household, taught in the day and boarding school, nursed her aged grandmother, and finally from a lively sense of duty to the poor opened a charity school. These labors proved too much for her strength, and at the end of six years her health failed. In 1827, when the Dix School was suspended because of her disability, she entered the family of William Ellery Channing, D. D., as governess and spent several successive summers at Portsmouth, R. I.

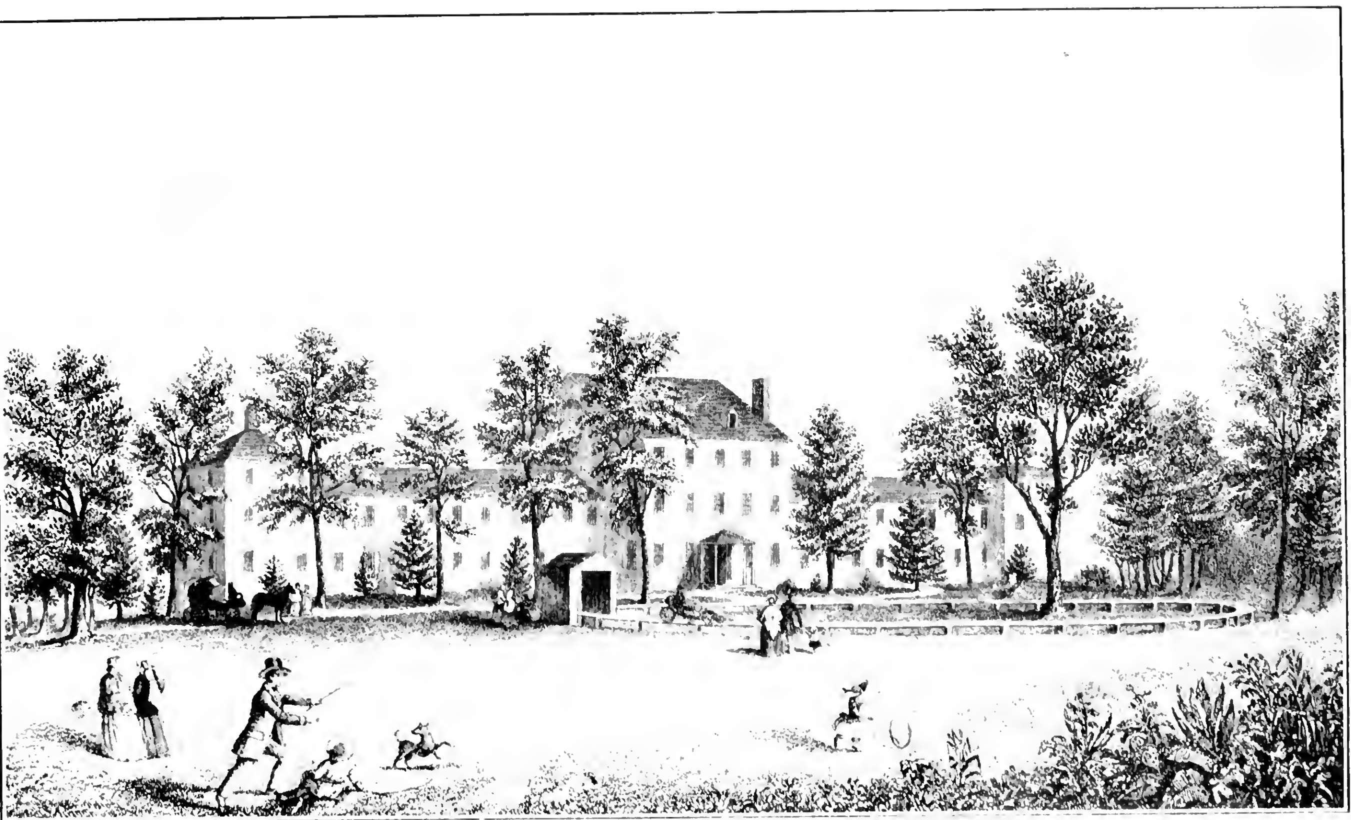
In 1830 she went to the West Indies with the Channings, and in this benignant tropical climate, surrounded by new and luxuriant vegetation, entertained by unfamiliar customs, and fascinated by the novelties of a new world, she found complete mental relaxation. Various branches of natural history attracted her attention, everything new in her experience receiving searching investigation and being catalogued in her memory, if not in her voluminous note-books. Geological formations, landscapes, flora, fauna, harbors, shores and ocean-currents, in short, all the novel phenomena

within her conscious horizon, engaged her critical interest now that she had time and opportunity to indulge her natural thirst for information. The keen discrimination shown in her reports and the value of the specimens which she collected elicited letters of appreciation from Audubon and Silliman.

At the end of her sojourn at St. Croix, Miss Dix found herself refreshed both in mind and body by the tropical climate, together with a complete relief from responsibility and hard work. In 1831 she returned to Boston and reopened the "Dix Mansion Day and Boarding School," an enterprise which embodied her most cherished ideas. The school was a great success and soon became known as a model. Miss Dix's riper age, fuller knowledge and wider experience made her an authority on education, while the ardor which vitalized all her projects made the school so popular that many pupils had to be rejected. The curriculum included little besides the common English branches of study but the drill in deportment and the fundamentals of a good English education was thorough and correct. For five years Miss Dix labored unsparingly in her school, but her undermined constitution could not support the strain involved, and in 1836 her health again failed. Her nervous system became exhausted, she suffered from pleuritic pains, and had frequent hæmorrhages.

In these five years she had established an enviable reputation as a teacher; she had housed, clothed and educated her dependent brothers, and she had accumulated a modest competence for future self-support, but all this had been accomplished at the cost of physical health.

The best medical opinion which Miss Dix could obtain recommended a voyage to Europe and a temporary residence in the south of France or Italy. She acted upon this advice, and, in the company of a friend, sailed from New York in April, 1836. When England was reached, however, she was too weak to travel by rail. Some English friends of Dr. Channing found her on a sickbed in a Liverpool hotel and insisted upon removing her to their country home, a few miles from the city. In this way she became an inmate of the hospitable dwelling, where she remained for 14 months a welcome guest and was most tenderly cared for, much of the time as an invalid or at best as a convalescent.



FRIENDS' ASYLUM, FRANKFORD, PA., 1835.

Miss Dix's mother and grandmother both died during her stay in England, and in 1837 business interests necessitated her return to America. Her health, though improved, was not firmly re-established, but as her brothers were successfully established in business, and the funds she had accumulated in teaching, increased by an inheritance from her grandmother's estate, yielded an income sufficient for her support, she was no longer obliged to keep up her school.

About this time she became interested in prisons and prison reform and in 1841, when 39 years of age, she entered upon the career which was to make her known to the world as a practical philanthropist. Never did the "massive gates of circumstances turn upon a smaller hinge." Some theological students in Cambridge had undertaken to teach a Sunday school in the House of Correction. One of them, J. T. G. Nichols, hesitated to undertake a class of 20 female prisoners and, on confessing his trepidation to his mother, was urged to consult Miss Dix, who quickly solved the problem by taking upon herself the task of instructing the women convicts.[1] Through this work she acquired an inside knowledge of conditions in the institution. She discovered overcrowding, uncleanliness and the herding together of the innocent with the guilty and the sane with the insane, a condition of things which at that time characterized the prisons and almshouses not alone of Massachusetts, but throughout the world.

Her first step was an effort for the relief of a few insane persons confined in bitterly cold rooms. She urged the official in charge of them to provide sufficient heat, but without success; on which she immediately applied to the judge, then holding court in the adjacent court house, and obtained an order requiring the keeper of the prison to heat the prisoners' quarters as she suggested.

Having reason to suppose that the insane in other jails and almshouses were improperly, if not brutally, treated, she began a personal investigation of all such institutions. The discoveries she made were shocking. In her school-teaching days of autocracy, justice with mercy was her guiding principle of action, and prompt action was her rule. This deeply grounded sense of the majesty of the moral law had not grown dim with age and experience, but

[1] Tiffany, p. 73.

intimate association with cultured people in the North and South and in England had somewhat softened her self-assertion, and she was now able to conceal her indignation until she could command the fitting occasion for reproof. There had never been a time when she would not have braved martyrdom if moved by the sense of righteous wrath, but she had now become mistress of tact and self-restraint, to be exercised when the object which she had in view demanded them. Impetuous as she was, even in her mature years, she always took the precaution to provide sufficient ammunition before she opened her batteries upon her opponents. In this, as in all her subsequent campaigns for the insane, she began by securing all the important facts, to which end she canvassed the whole state, carefully inspecting jails and almshouses and giving close attention to obscure cells and dark corners in order that no distressing case might escape her. She wrote accurate descriptions of everything disclosed by her search that deserved criticism, and arranged all this information in a systematic scheme.

In her first great public contest, she fortified her own convictions by consultations with a number of intimate friends; a group of broad-minded, public-spirited citizens, such as Rev. Dr. W. E. Channing, Charles Sumner, Horace Mann, Rev. Robert C. Waterson, Drs. S. G. Howe, Luther V. Bell and John S. Butler.

Her fight for the insane in Massachusetts reached its climax when she presented her "Memorial" to the State Legislature. It concludes as follows: "Men of Massachusetts, I beg, I implore, I demand, pity and protection for those of my suffering, outraged sex. Fathers, husbands, brothers, I supplicate you for this boon—but what do I say? I dishonor you, divest you at once of Christianity and humanity; does this appeal imply distrust? Here you will put away the cold, calculating spirit of selfishness and self-seeking, lay off the armor of local strife and political opposition; here and now, for once, forgetful of the earthly and perishable, come up to these halls and consecrate them with one heart and one mind to the work of righteousness and just judgment. Gentlemen, I commit to you this sacred cause. Your action upon this subject will affect the present and future conditions of hundreds and thousands. In this legislation, as in all things, may you exercise that wisdom which is the breath of the power of God." This indict-

to shape public opinion in such a manner as to secure the favorable support of the politicians. For nearly two years Miss Dix worked upon preliminary details. In 1845 her "Memorial" was presented to the legislature by Mr. Dodd, who also submitted a resolution proposing immediate action by the state to establish a public institution for the insane.[1] Subsequently the joint committee having in charge the hospital bill reported in favor of its adoption, declaring that "Miss Dix's Memorial presented the whole subject in so lucid a manner as to supersede the necessity for further remarks" as to the necessity for immediate action. The report concluded with an appeal for united support, acknowledging state delinquency and the reasonableness of the proposition. It admitted that patriotic, philanthropic, and Christian considerations demanded a state hospital for the insane; that New Jersey was "behind her sister states, behind the spirit of the times and the movements of the age," in withholding public provision for the better care of the insane; that the institution proposed in the bill would confer blessings to be felt immediately and for all time to come; that it would in short "reflect more lasting honor on the state and tell more for human happiness than all the legislation for the past century."[2]

Such a report would seem to promise certain success, yet the passage of this resolution was the occasion which, of all Miss Dix's reform movements, taxed her faculties most severely and witnessed her greatest triumph over difficulties. While legislation upon her hospital bill was pending, her energies were subjected to the most exhausting demands. Difficult problems would require comprehensive solutions, perplexing situations would develop with unexpected suddenness, or the question whether hostile movements should be placated or defied would call for immediate shrewd decision. Under these conditions, the exercise of political as well as common sense was essential, while familiarity with state affairs in general, a complete acquaintance with the facts involved, an accurate knowledge of human nature and a quick perception of character were imperative. Miss Dix endeavored to become acquainted with every member of the legislature, in order that she might fathom each man's mental endowment and moral standards, thus discerning his natural impulses and constraining ideals, besides gauging his sense of responsibility. With the knowledge

[1] Tiffany, p. 112. [2] Tiffany, p. 113.

thus obtained, she was able to correct the mistaken views of these men and to instruct and convince them in favor of expensive humane institutions, as well as to meet all the conditions that arose, but to accomplish ends called into action all her sense and all her intelligence, in fact every resource controlled by her great heart or within the range of her fertile mind. While thus engaged she wisely avoided entering legislative halls, and courtesy invariably assigned for her temporary occupation some adjacent room, library, alcove or quiet corner. Thither members of the legislature would come, some from inclination, others in response to an invitation from Miss Dix or from an ally, with divers objects in view; it might be to report progress, or to disclose fresh obstacles, to obtain information, or to argue certain points at issue, and it is surprising how completely philanthropists, political leaders and public officials tacitly acknowledged her supremacy in such affairs. In the evenings she often received such visitors, especially the recalcitrant contingent, in boarding-house parlors, and with these she would explain, expostulate and entreat, in behalf of the helpless insane, as though her own life were the impending issue. In a letter to a friend, written while conducting one of her legislative sieges, she disclosed how keenly she felt the magnitude of the job. "I must have sympathy," she wrote to Mrs. Hart, "just now I need calmness. I am exhausted under this perpetual effort and exercise of fortitude. At Trenton thus far all is prosperous, but you cannot imagine the labor of conversing and convincing. Some evenings I had at once 20 gentlemen for three hours' steady conversation."

The method by which she "convinced" members of the legislature will be understood from an incident which she describes in the same letter. One evening "a rough country member," who had proclaimed in public that "the wants of the insane in New Jersey were all humbug," came to her usual conference to convince her that his antagonistic views were substantially correct. "After listening an hour and a half," she says, "with wonderful patience to my details and to principles of treatment, he suddenly moved into the middle of the room and said, 'I bid you good night. For my part I do not want to hear anything more. You've conquered me out and out. I am convinced.'"[1]

[1] Tiffany, p. 115.

ment of the state practices was drastic, but, as usual with her onslaughts, it led to a proposition for immediate remedy, namely, the enlargement of the Worcester State Hospital.

Her friend, Dr. S. G. Howe, then a member of the House of Representatives, presented her petition and vouched for the truth of all the statements contained in it; nevertheless, it aroused a storm of angry protests. Public officials, interested politicians and their newspaper organs, all united to discredit the severe arraignment, alleging that Miss Dix had uttered false and libelous statements. She calmly replied that she had simply stated matters of fact which she was ready to substantiate. And here she took her especial attitude as a reformer, an attitude she always maintained in her work for the insane. She declared, with emphasis, that she was not actuated by vindictiveness or personal feelings towards the jailers and keepers, who were inflicting such harsh treatment upon the innocent and helpless, for she believed the horrible conditions surrounding the insane, which then existed almost universally, were due to an antiquated, ignorant and callous system of public policy based upon theories and practice which must be revolutionized out of respect to Christianity and advancing civilization. Public opinion raged about her, but the best sentiment of the community immediately rallied to her support, and the shrewder political magnates, forecasting the outcome, soon acquiesced in the impeachment.

As the indefensible facts gradually sank into the consciousness of the people, a wave of indignation at the tolerance of such wrongs spread through the community and so impressed the members of the legislature that they ultimately adopted the hospital bill by a large majority.

This great victory, the reward of singular ability and marvelous management, did not increase her self-complacency, but seemed rather to soften her. She came to a realizing sense of her personal power, but her mind was engrossed in the fact that there remained, in other states, throughout the land, thousands of insane persons whose keen sufferings would in no degree be assuaged by her signal success in Massachusetts.

She comprehended the serious conditions of the insane throughout the country, and to her understanding had been revealed the best method to arouse and energize indifferent sentiments upon

this neglected subject. She anticipated the Herculean struggle before her, and fully realized the bitter opposition she was destined to encounter, and the physical and mental exhaustion which might ensue; but such formidable presentiments of the consequences could not block her determination, and she consecrated the balance of her life without reserve to the cause of the wretched insane.

Convinced that it was the imperative duty of each state to provide more hospitals, or enlarge hospitals, for the insane, Miss Dix undertook to persuade or compel the various commonwealths to accept her ideals and adopt her suggestions. What others had evaded, she resolutely confronted, believing that where she could secure the necessary legislation, or obtain the requisite funds for such institutions, the desired solution of this burning question would naturally follow. Therefore, she restricted her efforts to the main object in view, relying upon others to work out the details of construction and internal management, and in all her subsequent labors she adhered in the main to this program.

Thus, having obtained her immediate purpose in Massachusetts, she turned her attention to Rhode Island, where conditions affecting the insane were no better than those which the State of Massachusetts had just repudiated.

Here again she conducted a thorough search in each city and township, laboriously recording the many discreditable instances of abuse and neglect she discovered, protesting to state officials, and seeking the co-operation of local philanthropists, as she unearthed case after case of barbarous treatment of unfortunate imbeciles and maniacs. Enlisting the aid of the press she caused to be published in the *Providence Journal*, April 10, 1844, the pathetic details of one pitiable case in particular. Other exciting articles and editorial comments followed, while at the same time Miss Dix was pleading with influential citizens to assist in arousing public abhorrence. Eventually her grim "Memorial" to the legislature was delivered. Her method of agitation, as was intended, produced a state of excited, almost violent, opposition against long existing conditions which most citizens, however kindly disposed, regarded as irremediable, though they knew them to be wrong. But fortunately for the reforms which Miss Dix undertook, she possessed unusual constructive genius. Although decided and rapid progress was being made, the development of

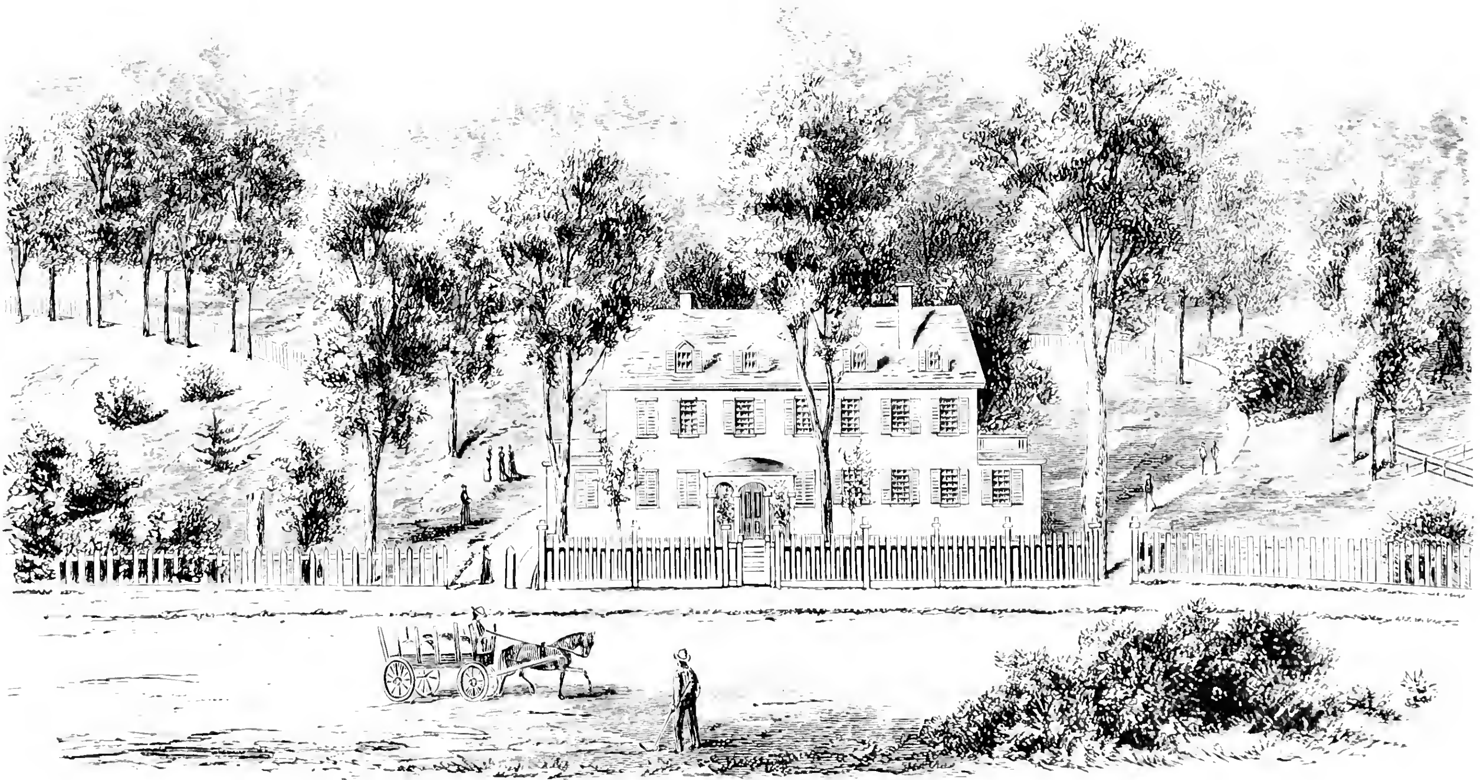
the grand action which she had staged moved too slowly to suit her impetuous nature. Scanning a list of prominent business men, financially able to assist her in precipitating a dénouement, she selected the name of Cyrus Butler. Now, Mr. Butler was wealthy, and his established reputation was notable, in respect of industry, frugality and good dividend-paying investments; but he was probably the last rich man in the state that well-posted charity agents would solicit for a large benevolent donation. Notwithstanding the hopeless predictions of her associates as to the outcome, she walked into Mr. Butler's office without the formality of an introduction. According to Tiffany's version of the interview which followed, Mr. Butler endeavored for a time to limit the range of conversation to general topics, the weather, etc. "Preserving her temper and self-control Miss Dix pleasantly adjusted herself to the humor of the scene until, feeling that the thing had gone far enough, she arose with commanding dignity and said, 'Mr. Butler, I wish you to hear what I have to say; I want to bring before you certain facts involving terrible suffering to your fellow-citizens all around you; sufferings which you can relieve. My duty will end when I have done this, and with you then will rest the responsibility.'"[1] Howsoever this interview terminated, it is believed in Providence that Mr. Butler had discussed this subject with other parties before Miss Dix saw him, and that he deliberated some time before he decided to contribute $40,000 to ensure the erection of Butler Hospital for the Insane. To found this institution Nicholas Brown, a merchant and philanthropist of Providence, had already bequeathed by will $30,000, and in view of the larger gift of Mr. Butler made during his life the first incorporated mental hospital in Rhode Island was given the name of the latter. Miss Dix's propaganda helped materially to inform and vitalize public sentiment regarding the insane in Rhode Island, and, being satisfied with the results, she selected New Jersey as the next field for her humane operations.

The lethargy of public sentiment in New Jersey, respecting insanity and its proper treatment, may be inferred from the fact that no institution whatever for the especial custody and care of the insane had been provided by the state. Miss Dix began an immediate personal investigation of the many jails and alms-

[1] Tiffany, p. 101.

houses. She recorded the details of all pertinent cases, and before her real purpose had become a matter of common information she had all the relevant facts and figures upon which to base criticisms, arguments and conclusions. This personal knowledge she wove into her New Jersey "Memorial," which was a brilliant summary of her observations, as well as a public impeachment like that which she issued in New England, though more moderate in tone and amiable in spirit. It is true that the insane in New Jersey were suffering under neglect and unsuitable surroundings, but in this indictment she made the rewards for benevolence towards them a central thought. The great benefits which might be conferred upon the afflicted insane with their responding gratitude were charmingly pictured. The softened style of this presentment was probably due to a politic consideration of those whom she was addressing. She had visited all sections of the state, had conferred with many of its leading citizens and had shrewdly sounded public sentiment, noting the bent of prevailing influences. She seemed to possess an instinctive faculty for discovering potential springs of action in the minds of others, with an alert capacity for adjusting her mode of attack or supplication, to accord with varying opinions and sentiments, as they predominated with individuals and communities. In the course of her philanthropic career she encountered thousands of persons, representing all grades of mental ability and all ranks of society, and but few individuals out of these multitudes were wholly indifferent to her adroit address, her fitly chosen words and the charm of her personality.

Before Miss Dix's advent many of the best people in New Jersey had become satisfied that public provision for the insane in their state was a pressing necessity, but these enlightened persons were outnumbered by a voting majority opposed to liberal state appropriations. Miss Dix's voluntary assistance in provoking discussion and educating public intelligence on this subject was, therefore, appreciated and welcomed by the better informed of the community. Under such salutary conditions, censorious statements would have been uncalled-for aggressions. The sympathetic and helpful friends whom she met (especially among the Quakers) strengthened her courage and so qualified the situation with which she had to deal, that she wisely modified her original style of attack. Nevertheless, it required vigorous and prolonged effort



BRATTLEBORO RETREAT (VERMONT ASYLUM). THE WHITE HOUSE, FIRST BUILDING, 1836.

Her methods have been described sufficiently to show her versatility in meeting both the ordinary and the unusual vicissitudes of a legislative campaign. In this particular instance she persevered with faith until her self-appointed mission in New Jersey was crowned with victory. Upon March 25, 1845, legislation reached its final stage and the Senate unanimously passed the reengrossed bill for the New Jersey Lunatic Asylum.

In Massachusetts and Rhode Island Miss Dix's aim had been to secure the enlargement of existing provision, but in New Jersey her design had no connection with antecedent institutions, and her efforts were directed to the establishment of a new and independent state hospital. Of her many successes in life probably none gave her such immediate and permanent gratification as the passage of this legislative enactment. She watched the beginning and the development of this magnificent charity with satisfaction and pride, and she often referred to this hospital as her "first-born child." She loved to visit and revisit this monument to her early struggle for the cause of humanity, especially when suffering from physical exhaustion and weariness of spirit as the consequence of arduous labor in other fields of duty. And when, by reason of her advancing years, infirmities incident to her age necessitated inaction, she joyfully accepted an official invitation to spend the remainder of her days within its hospitable shelter.

Miss Dix possessed extraordinary business capacity. However intent she might be on accomplishing some large purpose in a given state, she was, as a rule, engaged at the time in preparing for and developing movements of a like character in several other states. And she was able to do this without confusing matters of fact, mistaking the identity of individuals, or sacrificing interest in the details of each subject.

While absorbed in her New Jersey undertaking, Miss Dix had found time to journey extensively, always collecting first-hand information as to the conditions and the inmates of jails and almshouses. On one of these occasions she made a zealous quest in Pennsylvania, which she conducted with such efficiency that a bill founding an entirely new hospital for the insane passed the legislature at Harrisburg about the time the New Jersey state hospital bill passed at Trenton.

Her methods have been described sufficiently to show her versatility in meeting both the ordinary and the unusual vicissitudes of a legislative campaign. In this particular instance she persevered with faith until her self-appointed mission in New Jersey was crowned with victory. Upon March 25, 1845, legislation reached its final stage and the Senate unanimously passed the re-engrossed bill for the New Jersey Lunatic Asylum.

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Procrastination was impossible with Miss Dix and five days after the Trenton Hospital was legally established, she was on board a steamer, lying-to in a storm, near Charleston, S. C. While thus detained she wrote a letter in which she outlined her immediate plans. "I design using the spring and summer chiefly in examining jails and poorhouses in Indiana and Illinois. Having successfully completed my mission in Kentucky, I learned that traveling in the states referred to would be difficult, if not impossible, for some weeks to come, on account of rains and mud. This decided me to go down the Mississippi to examine the prisons and hospitals of New Orleans and return to see the state prison of Louisiana at Baton Rouge, of Mississippi at Jackson, of Arkansas at Little Rock, of Missouri at Jefferson and of Illinois at Alton. I took the resolution, being so far on the way, of seeing the state institutions of Georgia, Alabama and South Carolina. Though this had proved exceedingly fatiguing I rejoice that I have carried out my purpose."[1]

The prodigious amount of hard work that Miss Dix was able to perform amazed her friends more especially as her physical condition was precarious. All through her middle life she had recurring hæmorrhages, and after her journeys and labors in the Southern states she was frequently prostrated by malarial fever. She had few confidants, and even those so favored were able to trace her activities only in part. About the time the Trenton and Harrisburg Legislatures passed her hospital bills she indulged to some extent in personal reminiscence, when writing to her old friend, Mrs. Rathbone, of Liverpool. "I have traveled," she wrote, "more than 10,000 miles in the last three years. Have visited 18 penitentiaries, 300 county jails and houses of correction, more than 500 almshouses and other institutions, besides hospitals and houses of refuge. I have been so happy as to promote and secure the establishment of six hospitals for the insane, several county poorhouses and several jails on a reform plan."[2]

Each successive triumph in her philanthropic work increased public confidence, as well as her own faith in her ability to secure favorable legislation for humane purposes. She was constitutionally resolute, and with successful experience in arousing public

[1] Tiffany, p. 123. [2] Tiffany, p. 132.

sentiment and promoting appropriation bills, she came to possess a greater degree of assurance; relying at all times upon the support of an overruling Providence in a just cause, she feared no combination of circumstances. Her original methods of dealing with men and measures were incomprehensible to the ordinary politician. Her strategic arts baffled her opponents and seemed at times to acquire magical potency.

At Raleigh, N. C., she was coolly informed that the ruling party had resolved that no bill involving large expense should pass the legislature. Learning this fact, Miss Dix requested the leading Democratic members to meet her and when they were assembled, she thus addressed them: "Here is the document I have prepared for your assembly, I desire you, sir, to present it"; handing it to a man very popular in his party, "and you gentlemen," turning to the astonished delegation, "I expect will sustain the motion this gentleman will make to print the same." The papers were presented to the legislature, as suggested, and a motion to print 12 extra copies for each member was unanimously passed. Within six weeks a bill to establish the Raleigh Insane Asylum passed the assembly with only 10 opposing votes.

As her successful generalship in securing legislation for the insane extended, her services for such projects were more and more in demand. Often leading citizens, or an ambitious majority in some state, despairing because of inability to carry measures for their own insane, called upon her for assistance. Again, public officials, appreciating a necessity for new or enlarged institutions, yet dreading responsibility for suggesting the requisite appropriations, preferred to mask their designs by her prominence, and to follow her leadership. Yielding to such requests, or following her own ideas of duty and judgment, she toured through this country again and again, securing in most states improved conditions, if not radical changes, for the better for the helpless insane, and leaving along the way more than a score of important public institutions, each of which is a conspicuous monument to her extraordinary ability and her devotion to the cause of humanity.

During the winter she would confine her engagements to the Southern states, returning North as the spring advanced, and continuing her unselfish work in Canada through the summer. There were, of course, some interruptions to this general program. In

1854 she left the country and remained abroad for two years; and again, while the Civil War lasted, she was busy with general hospital work for the government.

The most ambitious scheme propounded by Miss Dix contemplated a public land grant for charitable purposes. Her first "Memorial," presented to Congress in 1848, called for a "grant of 5,000,000 acres of the public domain, the proceeds of the sale of which were to be set apart as a perpetual fund for the care of the indigent insane." This "National Memorial" was compiled from the state "Memorials" which had already done efficient duty, each in its own state, in connection with local legislation. It rehearsed the most flagrant instances of neglect and abuse of the insane as discovered by her in all the states. Pathetic, harrowing, almost incredible details were rearranged for effect upon Congressmen and the reading public, in terms so explicit, so positive and so unanswerable, that nothing short of consternation could result from their perusal. It opened as follows: "Present hospital provision, excluding institutions not considered remedial, relieves less than 3700 patients. Where are the remainder and in what condition? More than 18,000 are unsuitably placed in private dwellings, in jails, in poorhouses, and often most wretched habitations. I have myself seen more than 9000 idiots, epileptics and insane in these United States, destitute of appropriate care and protection; and of this vast and miserable company, sought out in jails, in poorhouses and in private dwellings, there have been hundreds, nay—rather thousands—bound with galling chains, bowed beneath fetters and heavy iron balls attached to drag-chains, lacerated with ropes, scourged with rods and terrified beneath storms of execration and cruel blows; now subject to jibes and scorn and torturing tricks; now abandoned to the most loathsome necessities, or subject to the most outrageous violations. These are strong terms, but language fails to convey the astonishing truths. I proceed to verify this assertion, commencing with the State of Maine." Each state in turn was accused of permitting all degrees of inhumanity towards its defenseless insane, and every charge in the declaration was substantiated by the history of cases, with the locality where found, etc., the names of the individuals involved alone being omitted. In conclusion, she assumed that the insane were wards of the nation, and reminded Congress that precedents

for granting her request were established when the United States Government donated portions of such common property to certain states for educational purposes and to schools for the deaf and dumb. Her " Memorial " was referred to a special committee and 5000 copies were ordered printed. A special committee room in the Capitol was set apart for her use by the courtesy of Congress; and when that body was in session she could be found at her post there, working with all her skill and power to secure the support of Representatives and Senators. This broad scheme of national charity was, as a rule, well received. Prominent members of Congress treated her with such respect and her proposed land grant with so much consideration, that she was encouraged to expect early and favorable action. Then, to strengthen her position and to show herself wholly consistent, she presented a second petition, praying for 2,000,000 acres more of the public land, for the benefit of the blind and deaf and dumb. While Miss Dix declared that she was never sanguine and confident regarding legislation, " only when a bill had passed into an act and is sealed by governor or president," a letter written by her on July 21, 1845, rings loud with assurance. She states the fact that the committee named by her had been appointed and that when her favorite chairman could not serve because of sickness, his official position had passed into the hands of one of her new partisans. " I really think," she wrote, " if Congress does not suddenly adjourn, I shall pass the bills, one asking for 5,000,000 acres of public surveyed land for the curable and incurable insane; and the other praying for 2,000,000 acres for the blind and the deaf and the dumb." Although, perhaps, warranted in believing that a majority of both houses favored her bills she could not obtain action, definite consideration being again and again deferred.

Before long an agrarian agitation started in the Eastern states and spread rapidly through the whole country. This popular expression of public policy induced the wary politicians to procrastinate with the land bills. Finally President Polk announced that he would " veto all and every land bill which did not make provisional payment to the general government."

Miss Dix noted every political move and estimated its force. In this case six months' observations and hard work convinced her that hasty action would be inexpedient. "I think the bills may be

deferred till the next session," she wrote to her brother, January 30, 1849. She hopefully suggested that President Polk's objections could be overcome by paying the government "a small premium upon each acre sold." "Fortunately," she adds, "I am on good terms with Mrs. Polk and the President." When Congress met in 1850 Miss Dix put in a revised bill, in which she had nearly doubled the amount of public land wanted for her benevolent purposes. She now saw need for 12,225,000 acres of the public domain, of which grant 10,000,000 should inure to the benefit of the insane, and 2,225,000 to that of the blind and the deaf and dumb.

Again her "Memorial" was well received by members of the House and was sent to a special committee. The press, in general, approved her consolidated bill. It was endorsed by the best leaders of public sentiment, while philanthropists and interested associations gave it their hearty support. The superintendents of American institutions for the insane voted: "That this association regards with deep interest the progress of the magnificent project which has been and continues to be urged by Miss Dix on the consideration of Congress, proposing the grant of a portion of the public domain by the Federal Congress, the proceeds of which are to be devoted to the endowment of public charities throughout the country, and that it meets with our unqualified sanction. (Signed) Thomas S. Kirkbride, secretary." Late in the summer of 1850 her bill passed the House of Representatives. She was kept in a state of mental tension for some time with hopes that the Senate would concur, and with fears that it might not; ultimately the bill was deferred until the next session. At the winter session Miss Dix resumed her efforts to get the bill through, and was well pleased when it passed the Senate on February 2, 1851. The bill had now passed both Houses, but final action in each had not been reached in the same session, consequently the bill had to go back to the House of Representatives for re-approval. But when it was sent back, parliamentary tactics were employed to avoid a decision. A rigid enforcement of the rules serves such a purpose at times. Twice the rules were suspended to take up the bill, but each time opponents, by adroit management, induced the House to proceed to business. By such methods, in spite of its many friends, the bill was again forced to lapse.

Non-propitious political skies led Miss Dix to wait nearly two years before she again appealed to Congress in 1852 for a land grant; and then she made but a feeble attempt to push its consideration. But when the session of 1854 opened, the prospects of the bill seemed brighter, as public discussion of the land grant scheme had subsided, and Franklin Pierce had become President, so it was again brought forward.

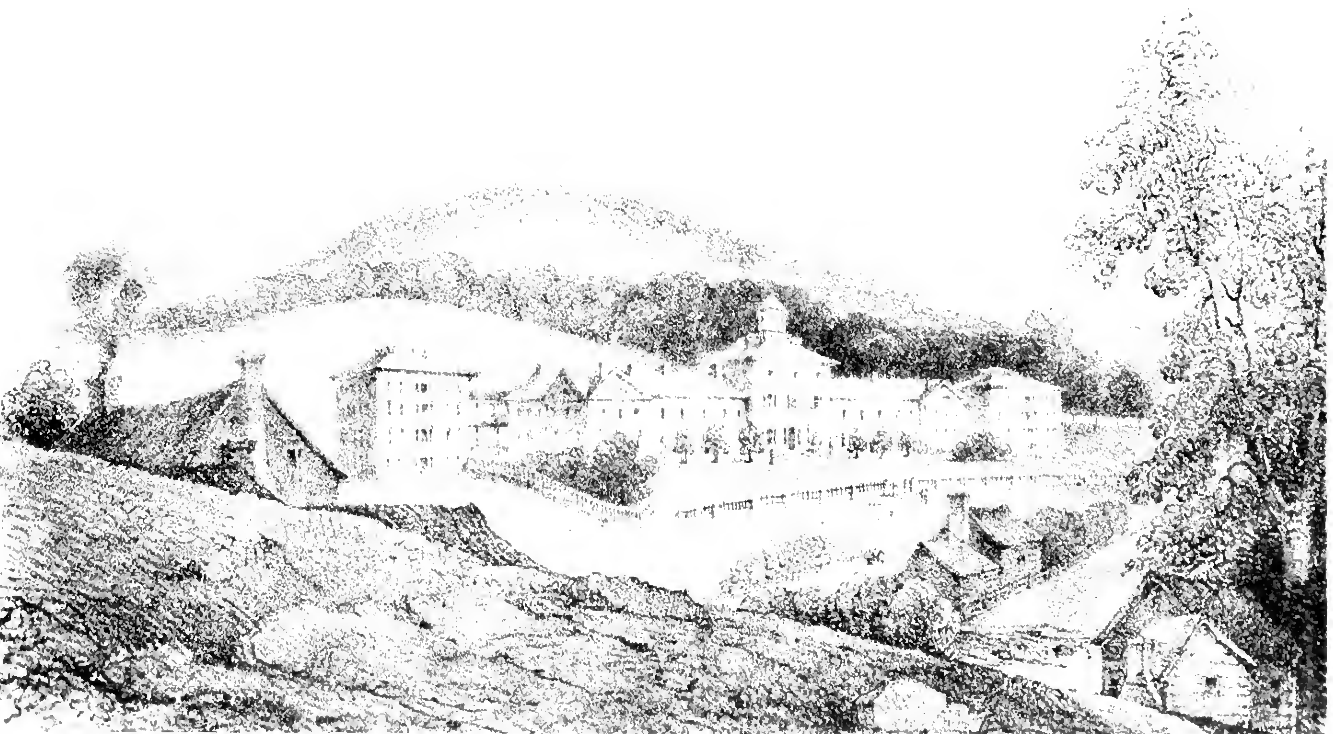
Meantime Miss Dix had worked hard in many states, and had won several glorious issues for the insane on Southern fields. She had good reason to expect that her rapidly growing national reputation had conferred upon her additional power of personal influence. Her native courage was undimmed and she was determined to push the land grant through Congress, if possible. She was never more resolute, never more buoyant in spirits and never better prepared for such an undertaking. Men who commanded great respect in both houses assisted her in advancing the measure and it passed the Senate by a large majority in March, 1854. Five months later it passed the House with 98 votes in its favor, and 84 against it.

Her biographer claims that this "Congressional achievement of Dorothea L. Dix will always stand out among the memorable moral triumphs of history." She received a flood of congratulations from the eminently good and wise, representing all sections of the country. Naturally she was elated and greatly encouraged, yet she was somewhat anxious while waiting for the signature of the President, which she fully expected would be attached to the bill. In this, however, she was doomed to disappointment. After six years of constructive presentation and devoted work upon innumerable details, after successfully coping with every hindrance and opposition thus far encountered, her wholesale charity plans in the interest of the insane were thwarted, and at the last possible opportunity for defeat, by President Pierce, who vetoed the bill, thereby, to use his own words, "resisting the deep sympathy of his own heart in favor of the humane purposes sought to be accomplished." He argued that Congress had "power to make provision of an eleemosynary character within the District of Columbia, but nowhere outside; that it had transcended its powers in those two instances where it had granted public lands to two schools for the deaf and dumb; setting up unsafe precedents,

examples to be avoided rather than followed." "If Congress has power to make provision for the indigent insane without the District," he continued, "it has the same power to provide for the indigent who are not insane, and thus to transfer to the federal government the charge of all the poor in all the states." This veto, this surprising and inexorable finality, was a cruel blow to Miss Dix; the most crushing indeed that she ever experienced. Hosts of friends hastened to express their sympathy, and "powerful rejoinders" condemning the spirit, as well as the text of the veto, appeared in the public press. The President's viewpoint, his logic and his conclusions were pronounced faulty, weak and absurd. But Miss Dix found little consolation in expressions of good-will or daring philippics. The reaction from overstrain, physical and mental, was extreme. She lost her nerve, and for the time being was unable to proceed with hospital work.

There remained before Congress another of her bills, one drawn to establish the Government Hospital for the Insane at Washington. It had then passed the Senate and, as subsequent legislation proved, was destined to be enacted before the session closed. But such reassuring facts and gratifying prospects were insufficient mental tonics to revive her paralyzed courage. Her mind and heart, so long subjected to exhausting tension, could not withstand the sudden collapse of her long cherished hopes; she desired nothing so much as complete rest and in her wretched state of discomfort no proposition having that object in view was so acceptable as a foreign tour. Accordingly, within two weeks she was on board a steamer bound for England. During the voyage her ruling passion for philanthropic work asserted itself. Through her assurance and extraordinary powers of persuasion she secured possession of the pools wagered upon the ship's daily run, as well as a liberal contribution from her fellow passengers, all of which money was to be turned over to the Home for Seamen's Children.

Back in Liverpool, entertained by the same devoted friends who 18 years before had lavished comforts and consolation upon her during a prolonged season of invalidism, she rapidly regained her optimistic spirit, and with it her renewed desire to serve the interests of the insane. Within a month she had resolved to investigate the hospital conditions in Scotland, though five months elapsed before she felt sufficiently recuperated to commence her remark-



WESTERN VIRGINIA LUNATIC ASYLUM, STAUNTON, VA., 1838.

able exploit in that country. Meantime she rested and enjoyed delightful associations with her Liverpool friends, interrupting her visit for a few weeks only, while she traveled and visited in Ireland.

In Edinburgh, as was the case everywhere she went, the best social circles received her cordially. Such affiliations always gave her pleasure, as she repeatedly acknowledged, but no personal considerations, no local conventionalities or official friendships, could divert her humane intent, once she discovered neglect or abuse of the insane. Without prejudice against Scottish institutions, she began to inspect those in and around Edinburgh. As she expected, the more prominent public institutions were well conducted, but to her amazement she found that serious abuses existed in the private asylums, and that the indigent insane all through Scotland were badly treated. Her familiarity with the solution of such problems enabled her to comprehend the situation at sight; and she wrote to a friend that, in Scotland, "hundreds of miserable creatures were suffering from a bitter bondage, concerning which the people at large were quite unconscious."[1] Realizing the importance of possessing definite information to form the basis of an aggressive public appeal, Miss Dix proceeded to accumulate a record of the hidden but damaging facts by a round of personal inspection, just as she had done in America.

To officials and to the general public it seemed presumptuous for this non-resident stranger to engage unceremoniously in a critical search through their public and private institutions for evidence of cruelty and injustice towards their irresponsible insane, and she encountered much opposition. Her friends, mindful of her recent breakdown, urged caution and delay, the mental and physical strain attendant upon persistent reformatory work being certain, in their opinion, to overtax her impaired health.

But Miss Dix was under the old spell—a compelling sense of duty combined with a prophetic judgment or veritable inspiration—and heeded neither the admonition of friends nor the denunciation of foes. In explanation of her course, she wrote to a friend as follows: "It is true I came here for pleasure, but there is no reason why I should close my eyes to the conditions of the most helpless of God's creatures. I am confident that this move rests

[1] Tiffany, p. 231.

with me, and the sooner I address myself to this work of humanity the sooner will my conscience cease to suggest effort, or rebuke inaction.[1] It is pretty clear that I am in for serious work both in England and Scotland. I do not see the end of this beginning, but everybody says, who speak on this question, that if I go away the whole work will fall off. So I pursue what I so strangely commenced."[2]

In Scotland many influences had retarded the practical application to the insane of the Christian spirit which animated Miss Dix. There were, however, many notable, philanthropic Scotchmen who painfully recognized the indefensible features of their public policy towards the insane. But hitherto their best efforts towards securing reforms had failed to accomplish any practical improvement, and they gladly welcomed Miss Dix, giving her substantial encouragement in her relentless grapple with public indifference and lax views of moral responsibility towards the insane.

In all her attempts to rectify mistreatment of the insane, Miss Dix worked quietly until in possession of sufficient incriminating evidence to warrant an open attack. She then reported actual conditions to the responsible managers and higher official authorities, urging immediate correction of faulty and abusive methods. Delayed reformation on their part was severely condemned, and grievous facts were then revealed to all interested parties, while startling reports and harrowing details appeared in the public press. Employing such methods, she soon aroused a reform agitation in Scotland, which rapidly extended over the community and caused vehement indignation. Despite her able management of the cause, however, and the public excitement which resulted, she could not secure favorable action from the officials in whom was vested ultimate authority over the insane and their management. When she appealed to the sheriff, who was virtually chief justice of the high court of the county, he "trifled, jested, prevaricated and ridiculed the idea of reform."

In time she realized that the Scottish authorities intended to defy her, and in a final interview with the local powers Miss Dix intimated, or threatened, that she would appeal to the British Home Secretary. The Lord Provost of Edinburgh apprehended

[1] Tiffany, p. 231. [2] Tiffany, p. 233.

that her attack signified danger and dreading the effect of her uncontradicted representation to one of the highest government officials of the kingdom, thought it expedient to see the Home Secretary himself at once and warn him against the "American invader," as Miss Dix had come to be characterized. Appreciating the importance of timeliness in attempts to discredit through covert methods, such a moral columbiad, he packed his trunk that night and early the next morning started for London.

A judicious precipitancy was a striking feature in many of Miss Dix's brilliant achievements. Her incentive in this instance may have been the natural outcome of constitutional habits, or a clairvoyant interpretation of the lord provost's mental resolutions; at any rate, while the crafty politician was sorting out his traveling wardrobe, Miss Dix caught up a small hand bag and took the evening train for London. She passed a sleepless night, and her train was belated, but she arrived several hours in advance of the canny Scot, who had aimed to forestall her. This was her first visit to London, but she was met at the station by a messenger from Lord Shaftesbury, to whom she had wired before she left Edinburgh.

A meeting with this most eminent friend of the insane was then and there arranged for the same afternoon. She had three hours to wait, but utilized the time in making a call upon the Duke of Argyle at Kensington. She stated her business and asked him to arrange for an immediate audience with the Home Secretary. The Duke was pleased to aid her and presently had arranged an audience for her at 4 o'clock. She then drove to keep her appointment with Lord Shaftesbury, who had the full Board of Commissioners with him. With them she discussed the whole subject, outlining the distressing conditions which existed in Scotland, and they agreed "that no time ought to be lost in urging the usually tardy Secretary."[1] Much to her regret the Home Secretary had been detained by a council meeting at Buckingham Palace and could not see her until the following day. At first, he expressed doubt as to his authority to issue a warrant for a commission without the sanction of the Lord Advocate of Scotland. But Miss Dix was importunate, and persistently sought out lords, dukes and commissioners for explanations, consultations and action. Ques-

[1] Tiffany, p. 248.

tions involving prerogative and authority had to be duly considered in several departments. For a number of days the issue was in suspense, but this group of statesmen had been so impressed by her statements that neither technicalities nor political expediency could suppress a growing demand for an official investigation; and at the end of one week the Home Secretary promised to have two commissions appointed, one for the purpose of inquiring into the state of lunatic hospitals; the other to consider the present state of the law respecting lunatics and lunatic asylums in Scotland. The order of commission was signed April 19, 1855, by Queen Victoria. Thus it came about, that seven months after Miss Dix had temporarily abandoned the cause of the insane in the United States, physically exhausted and utterly discouraged because her omnibus bill for the insane had been vetoed by President Pierce, she had secured from the English Sovereign a royal commission, the observations, reports and recommendations of which "actually revolutionized the lunacy laws of the land." From all sides, social, political and professional, the credit of inaugurating this hospital epoch, so momentous for the insane, was unreservedly given to Miss Dix. Addressing Parliament, Mr. Ellice said, "The commission was entirely due to Miss Dix's exertions," and "no one could read the report of the commission without feeling grateful to that lady for having been instrumental in exposing proceedings which were disgraceful to this or to any other civilized country." The Home Secretary, Sir George Gray, who had been such a prominent agent in the commission preliminaries, gave similar testimony in a speech before the House of Commons; but "deplored the fact that the inauguration of so needed a reform should have been left to the initiative of a foreigner, and that foreigner a woman, and that woman a dissenter."

D. Hack Tuke and numberless other mental specialists in Great Britain recorded their tributes of appreciation for her marvelous capacity for executive leadership, as shown in this movement; a reform which some of their most influential home leaders had attempted in vain.

When the members of the commission had been appointed, Miss Dix supplied them with facts and details from her notes, and advanced pertinent suggestions which greatly facilitated their subsequent investigations.

As soon as the pressure of important events relaxed, her own health again became the subject of her chief concern, and she sought rest, which was gratefully offered her in the quiet home of the Tukes at York, England. That her epoch-making battle for the Scottish insane was waged by a semi-invalid appears from a confession, written at this time, May, 1855, to her American physician and old friend, Dr. Buttolph, at the Trenton State Hospital: "Counting the time since I left the steamer (about September 15, 1854) I find that rather more than half the period I have been too ill or too languid to do anything." Another paragraph in this letter is of especial interest in connection with this sketch; it reads: "I am here in a comfortable, quiet apartment. In the room next to mine, retiring from the labors of an active life spent in the cause of the insane, lies helpless the good Samuel Tuke."[1] Another section of this confidential letter illustrates how Miss Dix's personal services were frequently called into requisition, and the significance she attached to such appeals. While in Edinburgh she met, by chance, Dr. Simpson and his niece, a lady living in the south of England, who asked Miss Dix if she had ever been in the Channel Islands, especially Jersey and Guernsey; and then gave an account of the abuses to which the insane were there subjected, urging Miss Dix to visit the Islands and rectify the wrongs. Miss Dix was at that time too deeply engaged in the Scottish work to do more than register a mental note in regard to the matter, but in this letter she refers to the incident as, "What in my case I call leads of Providence."[2]

While she was regaining her strength at York, Dr. D. Hack Tuke called her attention to a pamphlet, written by Dr. von Leuven, in which the sad conditions involving the insane in the Channel Islands were discussed. At her request Tuke wrote to the author for more explicit information. A reply came promptly, and she says in one of her letters, "The answer determined my duty and my next work." Dr. von Leuven had become alarmed because some of the most objectionable managers of private madhouses in England, menaced by the hostile public sentiment and restrictive legislation which Miss Dix had brought about, were re-locating their questionable enterprises in Jersey. It was two

[1] Tiffany, p. 259.

[2] Tiffany, p. 260.

months before Miss Dix felt able to go to the Island and undertake what in a private letter she had predicted she would do there, namely, "Helping out of dismal, dark dungeons those whose only crime is that they are sick-insane, and so feared and tantalized, till they are really what the sane would call them, mad-men and mad-women. . . . . I shall see their chains off. . . . I shall take them into the green fields, etc."

The middle of July found her there essaying the benevolent mission she had anticipated. The prestige she had gained by her unparalleled demonstration of power to influence public opinion and legislation in England, added weight to her judgment and dispatch to the execution of her plans. At her instigation, within one week's time the local authorities had met in full committee and "the resolution was passed to build a hospital for the insane with the least possibly delay." A few days later, in a letter to a friend, she wrote: "I have got a farm for a hospital. . . . . I have gotten Mr. —— (naming a sordid proprietor of a private asylum, recently transferred from England) into the hands of the high constable of Jersey, by the order of the governor and attorney-general. So that business is well settled."[1] Satisfied that the future well-being of the insane in the Channel Islands could be safely trusted to local protectors, alert philanthropists and the aroused authorities, within a month Miss Dix was away, to join old friends in Switzerland.

After a stay of a few months she resolved to inspect the asylums, hospitals and prisons in several other European countries. Accordingly by September 1 she had begun this tour of inspection, spending nearly five months in visiting the public institutions of France. In the main she was satisfied with the conditions she found there. Her criticisms were brief and mild. By the middle of January she was giving her unsolicited attention to similar institutions in Italy. In that country she found the institutional care of the insane to be generally bad, and in some instances extremely objectionable. When the conditions in any one institution warranted her expostulations she always reported the facts to the local chief of management, and to augment the force of her strictures, she usually filed written protests with the highest department or government official. From Turin she wrote:

[1] Tiffany, p. 270.

"Made an appointment with the chief doctor for to-morrow, ... shall try to represent the importance of entire change for the patients. . . . . shall appeal in writing to the King."[1] From Genoa she wrote: "I found at Rome a hospital for the insane so very bad I set about the difficult task of reform at once, and during the 14 days I was there, so far succeeded as to have Papal promise and Cardinal assurance of immediate action in remedying abuses and supplying deficiencies."[2] With faith in her mission, as well as her judgment, and moral courage equal to any humane demand, she had been before the Pope with her remonstrance. Tiffany narrates the circumstances of this courageous proceeding and describes her reception by Pope Pius IX as cordial and considerate. His Holiness was deeply interested in her account of existing wrong towards inmates in the local asylum, and decided on the spur of the moment that he would test the accuracy of her representations by a personal investigation of the institution in question: and Miss Dix was requested to repeat her visit within a few days. Meantime the Pope, without announcing his purpose, quietly appeared in the wards, and after a thorough inspection became convinced that she had revealed the actual truth. "At the second audience granted Miss Dix, the Pope freely acknowledged his distress at the condition of the asylum and the treatment of the patients, and warmly thanked her, a woman and Protestant, for crossing the seas to call to his attention these cruelly treated members of his flock."[3] A medical commissioner was immediately dispatched to France to study the construction and management of the best French asylums and within a reasonable limit of time the projected Roman hospital for the insane, designed to conform in appointment and the treatment of patients with the Dix standards, was pushed to completion.

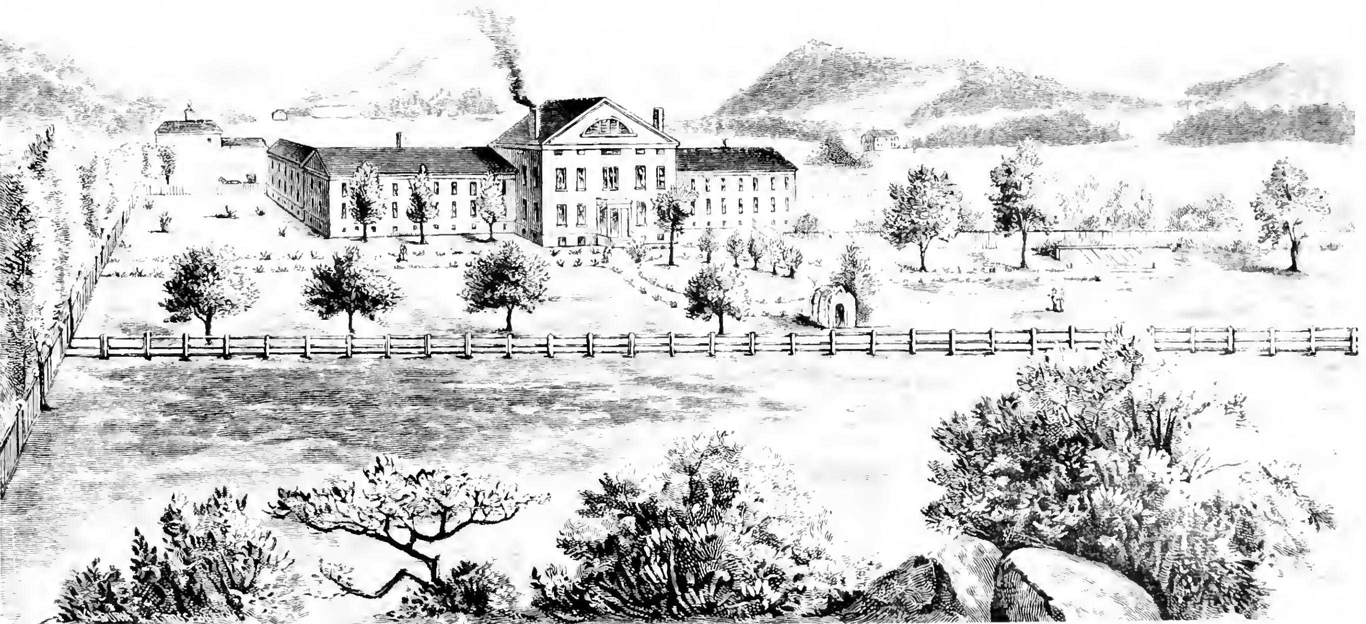
Assured that in good time such would be the substantial reward for her two weeks' labor in Rome, Miss Dix departed for Greece, where she spent several busy weeks visiting institutions, to determine the standards of care and appointments which prevailed in that country. As only scant records of her operations in Greece and the conclusions they called forth have been made public, it may be presumed that she found little to condemn.

[1] Tiffany, p. 285. [2] Tiffany, p. 284. [3] Tiffany, p. 289.

The next stage of her somewhat irregular journey ended at Constantinople, but she made hurried visits to several institutions at intermediate landing-places. Turkish treatment of the insane had been so harshly criticized by earlier travelers that Miss Dix was prejudiced in advance, and began her inspection of Turkish institutions prepared mentally for a strenuous contest with the authorities. But she was agreeably disappointed. Excepting one debtor's prison, she was admitted to all asylums, hospitals and prisons in and about Constantinople; and the Turkish officials treated her with marked civility. Outside the city she discovered some asylums where abusive treatment of the insane was tolerated, but these were Greek and Armenian institutions. All the Mohammedan hospitals were, in her opinion, better managed than the asylums she saw in Italy, and the hospital for Turks in Constantinople was a model, as regards provision for the comfort and the amusement of the patients. Dr. Cyrus Hamlin attributes this gratifying condition to the work and influence of a Turkish gentleman, who had been so impressed with the conduct of Paris hospitals that he had copied here, in his native city, the best French examples of insane hospital management.[1]

From Constantinople Miss Dix proceeded to Hungary by way of the River Danube. She also visited successively Austria, Russia, Sweden, Denmark, Holland and Belgium, spending about five months on this continuous tour. Along the way she utilized all the time at her disposal in observing the internal management of public institutions. Miss Dix had but a limited command of conversational French, but through that medium of communication and her native English, she made her way in and about these different countries, each having its special language, making her wishes sufficiently comprehensible for her purpose, clearly apprehending the import of all she observed, and invariably successful wherever she sought admission. In most places her fame had preceded her, so that her name was an "open sesame" to institutions in all enlightened lands. Applications, where necessary, for government passes were honored readily and not infrequently such favors were voluntarily proffered. A month before she reached Austria her *entrée* to all institutions of the empire had been courteously tendered.

[1] Hamlin's Letter, Tiffany, p. 302.



BRATTLEBORO RETREAT (VERMONT ASYLUM), 1844.

With or without official credentials, Miss Dix explored a sufficient number of European institutions to satisfy her immediate sense of duty, and decided to return to America early in September. She had been a voluntary exile for two years. When leaving her native land she was so exhausted in body and so downcast in spirit that prospects for future usefulness seemed dim and remote; yet in these two years she had established the most brilliant record of a brilliant career. She had to her credit, not only numberless deeds of mercy on a large scale in behalf of the helpless insane, but the fact that in the course of her labors she had prevailed with a leading imperial government and the world's most eminent religious potentate.

When back in the United States she found her peculiar gifts and phenomenal executive ability in greater demand than ever before. Requests for her especial attention and efficient services poured in upon her from nearly all parts of the Union, and she plunged into her work of benevolence with experienced judgment and the power of a clarified faith. She was besought for aid in securing the enlargement of existing hospitals, for advice in perfecting plans for new institutions and for help in obtaining necessary appropriations. The respect for her opinion in general was such that she was frequently called upon to settle the location of a new hospital where conflicting selfish interests had delayed action. Candidates for hospital positions desired her endorsement, and committees on hospital organization often deferred to her recommendation in appointing executive officers.

Though thus burdened with responsibilities for numerous and diverse interests, she always maintained her normal composure; managed usually to place herself in a commanding position, and generally said the appropriate word to the right party at the vitally important moment. At different times she found herself sponsor for and legislative manager of several important bills, under simultaneous consideration in as many different states. The celerity and apparent ease with which she would, under such circumstances, flit from East to West; from Canada to Texas, as her presence was required to advance her many plans, surprised her friends and worried those opposing her measures.

Upon such humane and public-spirited lines she toiled incessantly for five years, and then came the Civil War, which, for

the time, checked insane hospital construction in the North as well as the South. At the outbreak of hostilities Miss Dix recognized new obligations and new duties with her accustomed promptitude. The day following the "tumult in Baltimore" with the Massachusetts regiment, April 19, 1861, Miss Dix was in Washington and had offered to serve the United States Government in some hospital capacity. Because of her world-wide reputation for nobility of purpose, her extensive hospital work and her distinguished services in the cause of humanity, she was well-known and possessed the implicit confidence of the Administration. Without hesitation Secretary of War Cameron commissioned her as "Superintendent of Women Nurses, to select and assign women nurses to general or permanent military hospitals." This placed her in an autocratic position, and it has been claimed that for a time she exercised her superior privilege in regulating hospital management. But when the army had been thoroughly organized and chiefs of the medical department had seriously differed with her, she presumed less frequently or less positively to dispute questions of authority with them.

Noting that ordinary hospital stores were deficient in providing the delicacies essential for the comfort, if not for the recovery, of the sick in military hospitals, she began to collect clothing and medical accessories, refined foods, etc., from the Northern states, to be distributed to the sick Union soldiers. Although, at a later date, the Sanitary Commission occupied this field, Miss Dix maintained her personal depot to the end of the war, and in that way assisted thousands, receiving the gratitude of an army of suffering men.

She often visited the hospitals, especially those in and about Washington, and in the East, personally interviewing thousands of the wounded. Lossing's "History of the Civil War" pays her the following tribute: "Like an angel of mercy this self-sacrificing woman labored day and night through the entire war for the relief of suffering soldiers. She went from battlefield to battlefield, when the carnage was over, from camp to camp, hospital to hospital, superintending the operations of nurses, and administering with her own hand physical comforts to the suffering, and soothing the troubled spirits of the invalid or dying soldier; always burdened with words of heartfelt sympathy and religious con-

solation. The amount of happiness that resulted from the services of this woman can never be estimated."

As long as Miss Dix could follow her own views and vary her methods to suit changing conditions, she was a decided success, but she was not fitted by natural gifts, special training, or the experience of her life-work, to plan and control the internal affairs of a surgical hospital, while in selecting nurses she apparently deemed moral character the acme of qualifications. But in time she established an independent position for herself, and the things she did to relieve suffering are beyond compute. Although she encountered much opposition from hospital chiefs, her good intentions were never questioned, while her zeal and practical usefulness were universally acknowledged. Nominally she retained her commanding rank till the war was over, then Secretary of War Stanton, realizing that she would accept no pecuniary recompense for her more than four years of laborious service for the benefit of the Union soldier, ordered a stand of arms of the United States colors to be made for and presented to her, bearing the inscription: "In token and acknowledgment of the inestimable services rendered by Dorothea L. Dix for the Care, Succor and Relief of the Sick and Wounded Soldiers of the United States."

When the Civil War was over Miss Dix resumed her special work in the interest of the insane. Her usefulness to the unfortunate of that class was prolonged for 15 years, but limitations to her physical capacity developed as her years increased, while her pace slackened and the field of her activities was restricted in corresponding degree. In like manner her personal influence over current events in the realm of legislation and insane hospital construction bcame less and less active, but the powerful under-current of public opinion which she had stimulated into activity and directed into practical channels had become a world-wide, irresistible and permanent force.

No attempt to catalogue all her deeds of mercy and her achievements for humanity has ever been made, but there are imperishable records in abundance to show succeeding generations that she was a power for justice and mercy, and that the wrongs she corrected can never be re-enacted. There are now standing 32 institutions for the insane (according to Tiffany) [1] which were either

[1] Tiffany, p. 361.

founded outright, or greatly enlarged, as the result of her wise and practical efforts. Tributes of appreciation and respect have been engrossed on the archives of 20 states of the Federal Union, as well as on those of our Federal Congress, and the Parliament of Great Britain. Many societies, representing the best scientific and public interest, have placed on their records formal expressions of her worth and service. While she was in Scotland, arousing public interest favorable to the insane, "The Association of Medical Superintendents of American Institutions for the Insane," being in session, passed a resolution assuring Miss Dix that she was missed from the United States, that her return would be "hailed with pleasure," that the Association never met without many gratifying recognitions of her invaluable service to humanity, and that she "never held a higher place in our most respectful consideration."[1] The choice and able men who composed the Association in its early days were her warmest friends; she was always welcome to their official family circle, and was accorded every privilege in the wards of hospitals under their control.

Among those who were proud to befriend and co-operate with Miss Dix may be named Bell, Butler, Ray, Buttolph, Kirkbride, Earle and Nichols, as well as many others, whose names go to form the list of conspicuous American alienists of her times, while D. Hack Tuke, John Connolly and numerous other alienists in foreign lands recognized her great services in the cause of humanity and unstintingly applauded her methods and successes.

By requests from hospital managers Miss Dix was induced to give sittings to artists for 14 life-sized paintings of herself, to be placed on the walls of hospitals for the insane, in recognition of her work in their behalf, and as a reminder to those who have to do with this class of patients that high character and duty well-done call for respect and imitation.

It would be impossible to enumerate all the leaders of public affairs, men honored both in America and in Europe, who recognized her political sagacity and gladly worked under her leadership in promoting humane legislation for the insane. But the greatest fund of generous sentiment, approaching veneration, for this noble-minded woman existed in the minds and hearts of thousands of less illustrious people, inconspicuous men and women,

[1] Tiffany, p. 276.

who enjoyed some blessing derived, directly or indirectly, from her unselfish and wisely ordered labors. Such gratitude was indicated when a landlord in Texas refused pay for her dinner, because she had so befriended the poor and unfortunate. "No, no, by George! I don't take money from you; why I never thought I should see you, and now you are here in my house! You have done good to everybody for years and years. Make sure now there's a home for you in every house in Texas. Here, wife, this is Miss Dix! Shake hands, and call the children."[1] There was even a vague disposition to invest her with superhuman qualities. She was often termed the "patron saint" of the insane, and hospital managers instinctively selected the institution chapel as the most appropriate resting place for her portrait.

The wife of the Ambassador to France, Mrs. Walsh, voiced the feelings of a large class when she wrote concerning Miss Dix: "Such a woman is to be worshipped, if anything human could be worshipped."[2] Considering her humility of spirit, her penetrating judgment, her passion for justice, her courage and the compelling force of her personality, her biographer argues that her endowments and achievements rank her with that small class of canonized women who lived and molded great events in the earlier centuries of the world's history.[3] And it is quite probable that in past stages of civilization her exceptional gifts of mind and heart, finding expression in remarkable deeds, would have been regarded by a less well-informed or more superstitious people as miraculous.

To minds so predisposed there might be a suggestion of prevision in her words to Mr. Felton, president of the Philadelphia and Washington Railroad, in 1861, warning him that a conspiracy existed to prevent the inauguration of President-elect Lincoln, and that men in the plot were secretly drilling along the line of his road, over which the Presidential train was expected to pass. To nullify this evil design, Mr. Lincoln was brought into Washington secretly hours before the public had been led to expect him. Mr. Felton avers in a written statement that he "again and again, besought Miss Dix to permit him to make known how much the country owed her" in connection with this affair, but she always protested against having "any use made of her name."[4] Again,

[1] Tiffany, p. 370. [2] Tiffany, p. 275. [3] Tiffany, p. 290. [4] Tiffany, p. 333.

how easy, if people were credulous, to infer that she was possessed of superhuman power of presaging future happenings, when she made that apparently unnecessary trip to the wilds of Sable Island and witnessed a wreck on the treacherous sands, through which she incidentally discovered the inadequate life-saving apparatus provided by the Provincial government. Hurrying back to the States she consulted an expert on marine problems and collected from her personal friends sufficient funds to purchase four of the most approved life-boats, as well as a wagon and other accessories, necessary to properly equip the life-saving service. There were the usual delays in construction, and the extraordinary misfortune of partial loss when delivery was attempted. But, eventually, with some new parts and needed repairs, the whole consignment was established on the island, providentially as it proved, for in less than 24 hours after the arrival of the last, which was the largest and the most serviceable boat, an American steamship, having on board 180 persons, was driven on the fatal sand-bar by an ocean tempest. According to Dominion authorities none of the Island's boats could have lived in the strong gale and heavy seas which prevailed, but the Dix boats landed every individual. "My dear Miss Dix," wrote Miss Gurney, "I congratulate you intensely; I never heard of such a success, and to have it exactly the day after your boat arrived."[1] The Honorable Hugh Bell, of Halifax, wrote her in the same tenor, and added, "will you not rejoice at this result of your bounty?"[2] Her response to this suggestion of personal pride was exactly what might have been expected. With her habitual modesty and the superior poise which won her such universal appreciation, such triumphal leadership and such profound admiration, she hastened to give all credit to others concerned, immediately filing with the Mariner's Benevolent Society of London a statement detailing the disaster and the meritorious conduct of the life-saving crew, each member of which was duly awarded a medal in token of heroic services on that occasion. Her mental attitude in this connection exhibits the dominant traits of her character. Always thinking of and working for others, she sought no man's thanks, and seemed to be actually embarrassed when persons whom she had aided attempted to express their gratitude.

[1] Tiffany, p. 225.

[2] Tiffany, p. 221.

She was repeatedly urged to give the world an autobiography, but she could not entertain the proposition because it involved self-satisfaction and self-praise. All through her life she had intimate, confidential friends to whom she occasionally wrote in detail regarding matters which, for the moment, engaged her interest, but a request that such personal revelations be destroyed was usually appended. In many instances her injunction was ignored, and with such letters of this kind as were preserved, together with those from friends received and treasured by her, her biographer was able to construct a very interesting volume.

Her powerful imagination had, no doubt, much to do with fitting her for the great part she played in human affairs, but the control she exercised over it shows the advantage she derived from practical mental discipline. Passages in her early letters suggest that, when a school girl, her youthful imagination led her to extremes in religious experience, and that she almost realized the religious ecstasy resulting from mystical introspection and beatific aspiration. To a friend she wrote, " It is not that I would win the world's applause, or that I would possess a mind above the common sphere, but that I might have the luxury of those mental visions that must hourly entrance a spirit that partakes less of earth than of Heaven."[1] Fortunately her diffuse and intense religious feeling was so quickly regulated by her disciplined reasoning powers that all undue excitement was suppressed and her excess of emotion, prevented from exhausting itself in exaltation, was directed into altruistic endeavor. As a consequence the trend of her imagination became thoughtful and serious, rather than fanciful and romantic, and by the time she commenced her life work for the insane she had eliminated from her mental equipment whatever did not savor of wisdom or appeal to sound judgment.

Miss Dix contended with invalidism during the greater part of her life, and yet she lived to be 85 years old, dying in 1887. During the last five years of her life she was physically incapacitated, but her mind was unimpaired. To the last she retained an absorbing interest in everything affecting the insane, and cheerfully employed her enforced leisure in conversation with visitors, friendly correspondence and reading, especially enjoying devo-

[1] Tiffany, p. 25.

tional literature. Domiciled in the Trenton State Hospital, with every need supplied, she could have written volumes of reminiscences of surpassing interest and great permanent value, had she been minded to dwell upon the past, but she adhered to her life-long principle and persisted in looking forward.

Two years before her death she wrote to a surviving member of the Whittier family, at Oak Knoll, Danvers, requesting a written copy of "that heart penetrating poem of Mr. Whittier's, 'At Last.'" And this manuscript copy was found, after her death, under her pillow, and was read at her burial in Mt. Auburn Cemetery.[1] This much worn copy, kept always close at hand, suggests how frequently her thoughts must have been occupied with the sentiments that form the subject of the verses beginning:

> When on my day of life the night is falling,

and ending:

> There, from the music round me stealing,
> I feign would learn the new and holy song,
> And find at last, beneath Thy trees of healing,
> The life for which I long.

Certainly no description could more fittingly apply to her in these latter days than the significant words found in a letter of her own, written 32 years before to Dr. Buttolph, in which she describes the "good Samuel Tuke," then waiting for his final reward: "The Angel of Death stands at the door waiting; but the great blessing is deferred, the entrance into immortal life, where no clouds obscure the thought, nor hinder the spirit's growth."

[1] Private letter to Mrs. Woodman.

CHAPTER IV

METHODS OF CARE IN INSTITUTIONS

I.

EVOLUTION OF INSTITUTIONAL CARE IN THE UNITED STATES.

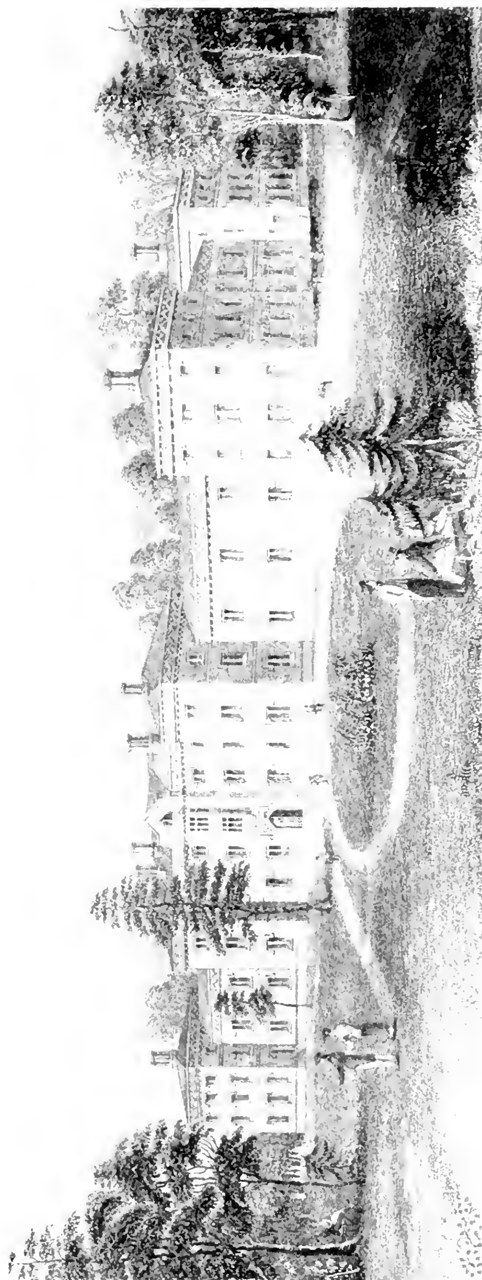
Prior to the nineteenth century the care of the insane in America was largely a local enterprise. There are records which show that in the early history of New York City the insane were cared for in an almshouse situated near the present City Hall, which had been built under the old Dutch administration and was designed primarily for the care of the friendless and destitute, both young and old, but at that period such an institution, though originally intended for the poor and friendless, was sure to become a receptacle for insane persons who could not take care of themselves or were unfit to be at large on account of dangerous propensities. The successor of this almshouse, which stood at that time on Kips Bay, East River, on the site of the present Bellevue Hospital, was also used for the care of the insane prior to the establishment of the insane department of the New York Hospital.

In Philadelphia, as will be seen elsewhere, the Pennsylvania Hospital was originally established to provide for the homeless friendless insane as well as for the sick who had no place in which they could secure treatment. It is true that the provision at the Pennsylvania Hospital consisted merely of cells in the basement and was only intended for persons who required custodial care. However, it is impossible to read the account of the Pennsylvania Hospital contained in Morton's excellent history, published at its sesquicentennial in 1901, without being convinced that the care and treatment furnished for the insane were fully equal to what were then supposed to be the requirements of such patients. There is no record, either in England or America, or upon the continent of Europe, of any provision for the insane at that date beyond custodial care. The safekeeping furnished by the small, inconvenient, ill-ventilated and, to modern ideas, wholly inadequate cells in the basement of the Pennsylvania Hospital included all that the mind of the public or of the medical profession conceived to be necessary.

It has been claimed that at Blockley Almshouse, now known as the Philadelphia Hospital, earlier and better provision existed. There is, however, no reason to think the institution was then other than an almshouse, such as provided shelter everywhere for the chronic insane, as well as haphazard and temporary accommodation for violent emergency cases. If any well-considered plan of caring for the insane in connection with the Blockley Almshouse had existed, surely Benjamin Franklin and his co-workers would not have appealed to the General Assembly of Pennsylvania in 1751 for funds to be employed in the erection of the Pennsylvania Hospital avowedly to take care of the insane.

It is well known that in many states the contract for the care of the pauper insane, notably in New England, was awarded annually to the lowest bidder. This was not due to the fact that the insane were less considered than other dependents; it was the custom thus to make annual provision for the care of paupers. In Connecticut, Massachusetts and New Hampshire the insane poor, being classed as paupers, were annually sold at auction to those who were willing to assume the care of such confessedly undesirable persons for a money consideration. Wherever it was not practicable to procure care for them in private families it was customary to confine violent, dangerous or untidy lunatics in jail or sometimes at home, in a strong pen, under the care of relatives.

It is especially interesting to note that in localities where the insane were cared for in this imperfect manner their condition appealed to the benevolent and philanthropic, and efforts were made by individuals to endow institutions for their better care and treatment. The Pennsylvania Hospital department for the insane thus founded developed into the present institution in West Philadelphia, which has had an honorable and useful career for more than 70 years. The insane department of the New York Hospital became the present Bloomingdale Hospital at White Plains, N. Y., through a similar growth and development. In Connecticut the Hartford Retreat, established by the State Medical Society, did excellent service in caring for the insane during a period of 40 years previous to the construction of the State Hospital. The same is true of Butler Hospital at Providence, R. I., which owed its establishment to private benevolence and for many years cared for the insane who needed hospital care under a contract with the



BUTLER HOSPITAL, PROVIDENCE, R. I., 1848.

state. In Boston, the McLean Hospital, a department of the Massachusetts General Hospital, performed a similar work for the state until such time as the Worcester State Hospital, a direct outgrowth of the Hartford Retreat, was established. In Vermont the charity of Mrs. Anna Marsh and her modest bequest of less than $20,000 gave birth to the Brattleboro Retreat, which was used by the state for the care of its insane for nearly 50 years and rendered the building of a state institution unnecessary during that period. In New Hampshire the State Hospital remains to this day a corporate institution, which provides for state patients and receives cases from the whole state. It is a matter of pride and satisfaction to lovers of humanity that enlightened private benevolence in many cases paved the way for proper state care of the insane.

In a few states mixed state and county provision for the insane existed from the start. In some instances county hospitals developed, because it was not practicable to induce the state to build a hospital sufficiently large to accommodate all the insane of a municipality or county. This was formerly the case in the State of New York. Many county hospitals for the insane poor were built in large cities, like New York, Albany, Rochester, Buffalo, Rome, Hudson and others, to provide for patients returned from state institutions or to accommodate cases which could not be admitted to them, or to serve as detention hospitals. Soon, however, owing to the vitality which local institutions even of this character sooner or later acquire, they became permanent, being encouraged and developed by local authorities in order that they might take the place of state hospitals.

In New York, after the enactment of state care, the inmates of such county and municipal hospitals for the insane were transferred to those belonging to the state, and the hospitals were converted to other uses, as at Rome, where a large county receptacle for the insane became an institution for chronic cases under state care; or as at Rochester, where the county hospital became a state hospital for the insane in the modern sense; or as at Buffalo, where a county institution was retained by the county and became a hospital for tuberculosis. Other states have had a somewhat different experience. In Michigan, for instance, an institution for the insane built at Eloise, near Detroit, still retains its individuality

as a county institution, but receives a subsidy from the state for the care of state patients.

In Illinois the institution established by Cook County, at Dunning, for the insane of Chicago and the vicinity, has been converted into a large state institution, and is wholly free from city and county control. In Delaware the state was for many years unwilling to build an institution for the insane, but finally at Farnhurst, near the City of Wilmington, it acquired rights in a county infirmary, which was afterwards developed by the state into a well-ordered institution for the state care of all of her insane. In New Jersey a number of county institutions sprang up for precisely the same reasons as in New York, namely, the inadequacy of state hospitals and the necessity of providing for the chronic insane in their home counties in order to relieve the state hospitals from pressure and to ensure accommodations within them for acute cases.

The history of Pennsylvania shows a backward tendency in consequence of a lack of forethought in the state's effort to care for her insane. State care was decreed prematurely, before sufficient institutions had been provided to accommodate the insane, with the result that all of them became hopelessly overcrowded and could not receive patients when application for admission was made to them. It became necessary, therefore, to increase the capacity of state institutions or else to license county institutions for the reception of state patients. As a result many counties in Pennsylvania have erected asylums under a law by which a certain proportion of the expense of building is reimbursed to them by the state and a weekly sum is received for the support of patients. The custody of the insane has thus become a source of revenue to the county, a mistaken policy that has tended to develop county institutions, which are now more firmly established than ever; but it has not improved the care of patients. What the result may be cannot now be foreseen.

A similar state of affairs exists in Wisconsin. In that state about 30 years ago, in order not to increase the size of the two state institutions for the insane, two classes of patients only were provided for: those of recent disease, who required special medical care and treatment, and those who were dangerous to themselves or others, so that their presence at a county institution was a menace to the inmates and their care a source of unusual expense

and difficulty. Under the supervision of the State Board of Control it became lawful for such counties as had a large number of chronic patients to build county asylums. Provision was also made by the state to pay a certain stipend to the county for the care of all patients maintained by it. It is claimed by its advocates that such county provision permits cases of chronic insanity to be cared for near their friends and to be visited by them more frequently than is possible at a state hospital at a distance; they have also, it is urged, better opportunities for congenial occupation and useful labor near their homes. On the other hand, it is asserted that under this system a county institution becomes a source of income to the county and that in some instances where patients are admitted from other counties the whole institution is maintained on the subsidy received from the state. A still more lamentable effect of the division of state and county care has been the lowering of the standard of care in the state institutions in Wisconsin. As the subject will be fully discussed elsewhere,[1] I will not refer further to the so-called "Wisconsin system."

In the opinion of the writer, a vital mistake was made by many states, especially by those which copied their methods from New York, in permitting the county a controlling voice in the disposition of the insane. In other words, many of the abuses which have arisen owe their origin to the fact that the insane have been classed as paupers, and not as hospital patients requiring special care. In New York, Michigan, Minnesota and other states, it was customary, when placing indigent insane patients in an institution, to recognize them as patients chargeable to the county of their residence and to compel it to pay for their care. It would have been wiser to consider them wards of the state from the moment of their admission to a state institution.

[1] See page 168.

II.

COUNTY CARE OF THE INSANE.

As has been pointed out in another section, the care of insane patients in counties originated when no suitable provision existed for their care elsewhere. They were homeless and dependent, and therefore objects of public charity, and they were cared for in almshouses as preferable to putting them in jails or confining them in pens or cells at home. County care was at first only an emergency provision and was so regarded. Almshouses for the care of the insane poor were established in the towns of Rhode Island, Connecticut and other New England states, as well as in a few counties in New Jersey, where the insane as well as any other persons who required custody were cared for under the charge of the selectmen. There was no thought on the part of the officers who took charge of the insane in this manner that such care would be other than temporary. In states where the county system of caring for the poor prevailed, which was generally the custom outside of New England, the insane poor were placed in county almshouses or in adjacent apartments especially arranged for them. Accordingly, in the history of every state we get records of town or county provision for the insane. Such provision was not organized into a system until it became necessary to provide for patients of a chronic class, who needed to be removed from state hospitals, designed for the care of acutely insane persons, in order to make room for more hopeful cases. As soon as chronic cases began to be removed, it became necessary for county superintendents of the poor to provide accommodations for them, which was eventually done by erecting buildings for the custodial care of the insane as departments of existing almshouses. These buildings were constructed at first to meet the exigency which had arisen and to prevent the state hospitals from becoming blocked by chronic cases. In addition to township and county care, there grew up in large cities a system of municipal care; for example, in Boston, the Boston Lunatic Hospital; in New York, the hospital on Blackwell's Island; in Philadelphia, the Philadelphia Hospital, better known as the Blockley Hospital; in Chicago, the Cook County

Hospital at Dunning; in Detroit, the Wayne County Hospital. These and other similar institutions built for the care of the insane of cities were avowedly for the care of all classes of the insane, both chronic and acute.

In order to improve almshouse conditions state boards of charity were established about this time in many of the states, which began their work by the inspection of existing conditions. The agents or members of these boards in New York, Massachusetts, Ohio, Michigan and other states found much to criticise and condemn in the conduct of these county establishments, and their criticisms, in many instances, caused county officials to build better institutions for the custodial care of the chronic insane, arranged somewhat on the plan of the earlier asylums or hospitals. In these the physical care of patients was often fairly good, but medical care, supervision and nursing were very generally neglected. The conditions which existed in New York are well shown by reports made by physicians in every county, collected in 1865 through the efforts of the New York State Medical Society. These impartial reports showed a condition of affairs which appealed strongly to the public conscience and finally resulted in the establishment of the Willard State Hospital for the chronic insane.

In New York, however, as well as in other states, county officials were reluctant to do away with institutions which had been built by local taxes, often at considerable cost. Local influence also was often exerted to keep the chronic insane in county institutions, because of a small amount of patronage and pecuniary advantage presumably involved in the local management.

Objections to the county system were numerous and of great weight. Its greatest fault was the fact that there was no uniformity in the care bestowed upon patients, nor was there any standard of care. Each county asylum was managed by local men, generally without experience or adequate training and with only a limited knowledge of the requirements of such an institution. They were not under the control of medical men and their management was more apt to be governed by considerations of economy rather than of humanity. In consequence of these conditions, as many systems of management were evolved as there were counties, and the insane thus sheltered failed to get uniform care or adequate or proper treatment.

In one state, Wisconsin, the care of the insane in counties was adopted as a policy of the state and became a definite part of the state system for the insane. Full particulars of this mode of care will be given in another chapter. It is sufficient to say here that the system has had many advocates in Wisconsin and many critics elsewhere. The example has been followed to a limited extent in other states, but the consensus of opinion seems to be that state care is preferable to any system of county care, however excellent.

III.

CHRONIC AND INCURABLE INSANE.

Up to the year 1864 no special provision had been made for the chronic and incurable insane. In New York, where the first steps in this direction were taken, it was not compulsory to send an insane person to a place of treatment (criminals excepted) or even to a place of detention. There was, in fact, a provision in the lunacy laws which permitted or rather required the medical superintendent of a state asylum, at the expiration of a certain period, generally thirteen months, to return the patient to the care of the county poorhouse, if, in the judgment of that officer, the patient was incurable or was a case of chronic mental disease not likely to be improved by further treatment. At this time the county poorhouse of earlier days had not undergone much change. It received the honest as well as the vicious poor, orphans, abandoned children, idiots, degenerates, and the aged and infirm, together with the insane, all under one roof, with limited facilities, or, it might be, with no facilities at all for classification. The insane were of necessity much restricted in their liberty and were often confined in cells under mechanical restraint with leather muffs or irons, besides being subject to abuse and neglect. The practical administration of the laws produced a separation of the insane into two classes, namely, the recent and probably curable, and the chronic and probably hopeless, the question of the final disposition of each class being decided largely by the cost of maintenance in a hospital, if troublesome, or in an almshouse at a considerable reduction of expense, if quiet, a policy which was yearly adding to the number to be maintained in houses already overcrowded.

The system of county care of the insane had become so thoroughly intrenched by usage and patronage that it had survived two public exposures in which the counts of the indictments alleged abuse, deficiencies, and neglect. But in 1864 the State Medical Society of New York approved a recommendation for the appointment of a commission empowered to visit all asylums and poorhouses in which the insane were confined and further resolved to

appoint a committee of the society to confer with the commission appointed by the Senate and Assembly. This committee consisted of Drs. Charles A. Lee, S. D. Willard and George Cook. The joint committees formulated a bill directing the county judges of every county in the state to appoint a physician of the county to visit the poorhouses and report upon the situation and condition of the insane confined there, the report to be sent to the secretary of the State Medical Society, Dr. S. D. Willard. The various reports, 53 in number, formed the basis of a further report which Dr. Willard presented to the Legislature, with recommendations, on February 5, 1865.

The Governor of New York, Reuben E. Fenton, in transmitting Dr. Willard's report to the Legislature, pointed out that in 53 counties, not including New York and Kings, there were 1345 lunatics confined in poorhouses, or poorhouse asylums, nearly all of whom were incurable, while many had become and others were fast becoming incurable from inefficient care and treatment. "The time has come," he said, "when legislative provision for them should be made. The propriety of establishing an institution for incurables—an institution that shall relieve county authorities from the care of the insane—should be deliberately considered."

"More than one-fourth of this number of insane," he continued, "are capable of some kind of labor. To what extent that labor, organized and systematized, might be made productive in the maintenance of an institution under well-directed medical superintendence is likewise worthy of consideration."

In accordance with Governor Fenton's recommendation, Dr. William H. Richardson, of Essex County, chairman of the Committee of Public Health, introduced a bill entitled "An Act to Authorize the Establishment of a State Asylum for the Chronic Insane and for the Better Care of the Insane Poor, to be Known as 'The Willard Asylum for the Insane,'" which became a law on April 5, 1865. This bill contained the positive requirement that "the chronic pauper insane from the poorhouses and all chronic pauper patients that shall be discharged not recovered from the State Lunatic Asylum (Utica) shall be sent to the asylum hereby created," thereby preventing their transference to the county poorhouse, as had been the legal disposition of them up to this time.

The enactment and application of the principle of the "Willard law" was the entering wedge in a scheme destined eventually to supplant the system of county care and later to establish the present system of state care in its place.

During the consideration of the bill Dr. Willard died in March, 1865, but his name and his memory are perpetuated in connection with the hospital he was instrumental in creating.

Drs. John P. Gray, John B. Chapin and J. T. Williams were appointed by Governor Fenton commissioners to locate the asylum, prepare plans for its construction, and erect the buildings. The property selected for its site had formerly belonged to the State Agricultural College. It was situated near the village of Ovid, on Seneca Lake, and the title to it was acquired in December, 1865. In the spring of 1869 the Legislature abolished the building commission and conferred its powers and duties upon a board of trustees. The trustees appointed Dr. John B. Chapin to be superintendent of the asylum and on October 13, 1869, the first patients were received from Columbia County.

It was anticipated that the patients selected for transference to the asylum would represent various mental and degenerate conditions, and the commissioners bestowed careful attention upon a scheme which should meet these conditions. It was necessary in their opinion to make a departure which in some respects would be radical, but which nevertheless seemed fully warranted by existing intolerable conditions. Their governing intentions were to remove chronic or incurable cases among the pauper insane from the poorhouses, to devise improved plans for their housing which should lessen the *per capita* cost of construction and by aggregation of numbers reduce the cost of support; to avoid duplication of service, and, lastly, to establish as a principle the humane disposition of the insane under responsible professional supervision and state care. All of these objects were accomplished by the erection of groups of detached buildings which were found to cost two-thirds less than accommodation prepared in accordance with plans usually adopted. The "Willard law," so called, may be said to have fairly accomplished the work its friends set out to perform through it, and its indirect influence, by the substitution of supplemental buildings, or blocks, or cottages, in place of large congregate structures, has been widespread and has con-

tributed greatly to the present comprehensive system of state care of the insane in New York. Moreover, by means of it the supreme power of the state, which had hitherto been exercised over the estates and persons of orphans and destitute children, was extended, so as to include the insane and whatever might conduce to their welfare. The recognition and adoption of this principle, together with its enlarged application according to modifications made by succeeding legislation, are to be recorded among the humane and scientific achievements of the age in which we live, by which the most cherished desires of the friends of the insane have been realized.

In June, 1865, at a meeting of the Association of Medical Superintendents of American Institutions for the Insane, the question of caring for the indigent and incurable insane was introduced by Dr. Butler, of Hartford, Conn. He said that in former years special provision had been made for the curable insane, but at that time there was no thought of conditions which had since then arisen, involving the necessity of providing for chronic and incurable, as well as acute forms of insanity. In Connecticut, at the time he spoke, there were fully 500 cases, which, although incurable, needed hospital care, and he asked: What should be done with them? Two methods of providing for them, he said, suggested themselves to him: First, that separate institutions should be built for incurable cases, a plan which he feared was impossible. Second, that farms should be provided for the permanent disposition of incurables, where their labor might partially meet the expense of their support.

In the discussion which followed considerable disinclination on the part of members was developed towards drawing any line of distinction as to provision or treatment between incurable and curable cases. Dr. Chipley, of Kentucky, was opposed to any classification which did not exist in well-regulated hospitals. He had known many patients who had been apparently incurable for years and yet who had recovered; he hoped never to see establishments for the insane under the charge of keepers and the old arrangements for the care of incurable patients. If the insane were to be cared for on farms, why should not the farm be connected with institutions already established? He wisely thought that the question of profit from the labor of inmates of institutions should never be entertained.

Another member, Dr. Hills, of Ohio, felt that though in Ohio the institutions had been increased in number, the increase of the insane had been greater in proportion, so that not more than one-half of the insane of the state were at present cared for in state institutions, the remainder being provided for in workhouses, jails, or under the care of their friends. He believed it to be wrong to reject a curable case from admission to an institution in order to keep an incurable patient under treatment. Dr. Gundry asserted that the idea of separating the insane into two classes might appeal to the political economist who could comprehend nothing beyond dollars and cents, but by professional men it must be viewed differently; he contended strongly that all insane persons must be cared for; he did not believe that incurable patients could with safety be withdrawn from institutions because their presence was valuable in aiding curable cases. He thought that separation would be injurious to the interests of the insane generally. Dr. Kirkbride also believed separation to be wrong.

As a result of the discussion a resolution was adopted appointing a committee of three to take into consideration the condition of the chronic incurable insane and the best possible arrangements for their custody and to make a report to be submitted at the next meeting of the Association.

At the next meeting of the Association at Washington in April, 1866, the committee thus appointed reported a series of resolutions and a paper was read by Dr. George Cook on " Provision for the Insane Poor of the State of New York," which covered much the same ground as previous papers. The report and paper evoked an extended discussion from Dr. Brown, of Bloomingdale Hospital, from Dr. Van Nostrand, of Wisconsin, Dr. Walker, of Boston, Dr. Peck, of Ohio, Dr. Ranney, of Iowa, and Dr. Gray, of Utica. The last of these made an earnest plea against the separation of the chronic from the acute insane, urging that the State of New York be divided into three hospital sections and that each hospital be provided with separate buildings for chronic and incurable cases, located largely upon farms in order that the labor of the insane might be utilized to assist in their support.

The discussion continued throughout two days and considerable feeling was excited among the members. Finally, a resolution presented by Dr. Cook providing for the separation of curable and

incurable patients in institutions of different grades was defeated and the resolutions proposed by the committee were adopted in a modified form. They recommended that ample and suitable provision for both classes of patients alike should be made in every state.

It is interesting to note at the present time, after a lapse of nearly 50 years, that the majority of efforts to divide the insane into two classes, chronic and incurable, have failed and that the institution at Willard, designed wholly for chronic cases, has for years been used as an institution for the treatment of all classes of the insane developing in the district composed of counties adjacent to it. It now forms one of the 13 institutions of New York devoted to the care of both acute and chronic insane.

In connection with this discussion the *Journal of Insanity* published an elaborate editorial, probably prepared by Dr. Gray, as a comment upon the paper of Dr. Cook. In this occurs a letter written by Dr. Brigham, then at Utica, to Miss Dix, which is worthy of reproduction. He said:

After much consideration, I feel constrained to oppose the establishment of hospitals solely for the incurable insane. They would, in my opinion, soon become objects of but little interest to any one, and where misrule, neglect, and all kinds of abuse would exist and exist without detection. I am opposed to them; principally on these grounds:

1. Who can say which patients are and which are not incurable? Of 200 now in this asylum (Utica) neither Dr. Buttolph nor myself, nor any one else, can say of at least one-third to which class they belong. There is hope in their cases, but this hope would be destroyed by sending them to an incurable establishment. The fact that the chance of recovery would be diminished to even a few is enough to make us hesitate before establishing such asylums.

2. Many that are incurable are monomaniacs, that are deranged but on one or two subjects, but rational on others; such surely should not be deprived of any comforts that are afforded to the curable class, among which the greatest is the hope of again being restored to society, which would be destroyed if they were sent to an incurable asylum. Equally, or more strongly, does this objection apply to cases of remission—to those numerous cases in which insanity is exhibited for a week and followed by several weeks of sanity. Shall these be told there is no hope for them?

3. Among the incurable insane there would be no certain means of ascertaining the neglect or abuse of them. In all asylums the fact that some are well and soon to leave the asylum is the greatest safeguard against abuse. It is so considered by all who are much acquainted with asylums for the insane.

NEW YORK STATE LUNATIC ASYLUM, ABOUT 1850.

4. No possible good would arise from such district asylums except they might be conducted at less expense. But how so, if they are to have proper officers, physicians, etc.? and if they do not, why are they better than county houses?

5. We have had no experience of such establishments. I have never seen but one such, and that was at Genoa—where the clashing of chains, the howling, groans, and curses gave to the place the appearance of the infernal regions; where no patient is ever expected to leave until dead; where hope never comes.

No, do not, in mercy to the insane, establish asylums for the incurable alone, but provide good asylums for all, and let all have the same kind care, and indulge the same hopes (even if delusive to many) of ultimate recovery, but do not drive them to despair by pronouncing them incurable.

An elaborate paper from Dr. John B. Chapin, the first superintendent of Willard, was also published in the *Journal* in which he makes a strong defense of his plan to provide for the chronic poor insane of the state, not on the ground that it is the best method of providing for them, but because the experience of New York and of other states has been that it is not possible to induce the state to provide for chronic patients in the more expensive institutions arranged for and especially built for acute cases. He saw no other way of preventing the lamentable discharge of chronic cases to poorhouses than to provide a cheaper grade of accommodations in connection with a separate institution. He made it clear that the object of those who urged the Willard law was to take the chronic insane poor out of the county almshouses and to provide for them in state buildings under state care so that their condition might be made as comfortable as possible.

He cited the experience of other states, like Massachusetts, and the province of Ontario in Canada, in support of his project and believed that the establishment of Willard would mark a distinctive advance in the care of all the insane of the state.

Immediately following this article was one by Dr. Benjamin Workman, assistant superintendent of the Lunatic Asylum at Toronto, in which he gave figures in reference to overcrowding of institutions for the acute insane in Canada and the necessity of providing for incurables (in 1859) in branch asylums, at a distance of three miles from the central institution, under the care of a steward and matron with a sufficient staff of attendants and facilities for utilizing their labors. He also spoke of providing a branch asylum at Malden, in which there were 200 patients with a qualified medical superintendent.

He added that in 1861 a half-finished brick hotel in the village of Orillia had been purchased and fitted up, to which 132 patients were transferred from Toronto. Notwithstanding all these efforts to care for the insane, there were, at the date of writing, more than 200 applications from patients who could not be admitted, and two wings were being built to enlarge the Toronto Hospital, thus furnishing accommodations for 250 additional patients. He called attention to the fact that these branches were not placed under county or municipal management, but, being under the care of the province, were subjected to the same visitations by inspectors as other institutions. He also pointed out that branch asylums for chronic cases have to a limited extent been curative, and that patients have been made very comfortable in them during the year.

As to the question of the profit to be derived from the labor of chronic insane patients, he said that while such labor is valuable, especially in farming operations wherever an auxiliary is established, it cannot be made so profitable as to render the institution self-supporting, since whatever work is done must be done under certain disadvantages, and necessitates the supervision of experienced persons. The form of labor which he considered most desirable is that upon a farm. Finally, he drew the following conclusions:

1. That the branch institutions for the chronic insane above referred to have secured to the inmates non-restraint methods almost entirely, a general cheerful condition of comfort, and a good diet.

2. That they have been conducive to recoveries, which might not have occurred had not the patient been sent to these institutions, where a freer life was possible.

3. That their hygienic conditions have been satisfactory and the mortality rate has been small.

In this connection, as foreshadowing a boarding-out system and the establishment of colonies for the chronic insane, an article by Dr. Pliny Earle "On Prospective Provision for the Insane," published about this time, is of much interest. In this Dr. Earle declares:

1. That some quiet, incurable patients, can be as well taken care of in their own homes as anywhere else.

2. That as there are not a few who have no homes, but who do not require the restraint of an institution, they can be well cared for in connection with respectable people who wish to take them as boarders.

3. That for the other two classes, *i. e.*, the curable and chronic, there should be a hospital for curable and a colony or institution for chronic cases. He did not believe in the absolute separation of the curable and incurable classes, but thought it preferable that they should be associated upon the same grounds though not necessarily in the same building.

It is worthy of note that the general expression of opinion on the part of hospital superintendents then, as now, seemed to be that it was not wise to separate the acute from the chronic cases.

IV.

THE COLONY SYSTEM.[1]

The Kalamazoo State Hospital is accredited with being the first institution of its kind in America to attempt the colonization of the chronic insane on farms.

In 1885 a tract of 250 acres of productive land, situated about three miles north of the parent institution, was purchased for a dairy farm and a cottage was erected to accommodate about 45 men patients, to be employed in looking after the herd and in raising general farm products. This addition to the institution was known as Brook Farm.

This venture not only " fully met the immediate expectation of the officers and trustees by furnishing milk to the institution and occupation for the patients," but it also " suggested how other supplies and increased accommodations might be provided at a much reduced cost to the institution and to the state."

In 1885 the trustees considered the further extension of the institution by what they were pleased to term the colony system. The original plan contemplated the aquisition of a large tract of land in some farming community near the institution, the erection of suitable cottages, each with a capacity not exceeding 30 patients, a residence for the physician in charge, a chapel and an amusement hall, and the necessary farm out-buildings.

Pursuing this plan the trustees in 1887 and 1888 sought to enlarge the colony already started, but were unable to obtain land adjacent to Brook Farm. They, therefore, acquired a tract of 357 acres 2½ miles southwest of the parent institution. Two hundred acres of this tract consisted of tillable, productive farming land, about 40 acres were of oak and hickory lumber, while the balance consisted of pasture land and lakes. The grove was so situated that it skirted the shores of and overlooked the lakes and formed a park to which the name Fair Oak was given.

The hope of the originators of this plan was to obtain in one tract sufficient acreage for diversified farming, but a sufficient appropriation could not be obtained from the Legislature.

[1] By Herman Ostrander, M. D., assistant superintendent.

The colony at present has one cottage accommodating 72 men patients, three attendants, five farm employees and one cook; three cottages for women with a total capacity of 245 patients, one supervisor, 14 nurses, including night nurses, and three cooks; one physician's residence, one large building containing a central heating plant; a general dining-room, easily converted into a dance and amusement hall; a laundry and sewing room, and a home for nurses. The buildings are lighted by electricity from a central power plant at the main institution.

The colony has its own supply of water from drive wells, the pumps being operated by electricity, also supplied from the parent institution. The disposal of sewerage is by the intermittent subsurface system. The institution has complete control of the lakes on the colony property and they are kept well stocked with fish.

Boating and fishing afford recreation for the patients.

The farm supports a large herd of cattle for dairy purposes and for beef. It also supplies the colony and to a considerable extent the main institution with vegetables. The farm work is done entirely by the patients under the supervision of the farm supervisor. The women are employed in housekeeping and in caring for the lawn and flower beds. They do all of the laundry work for the colony as well as their personal laundry, make most of their own clothing, and in the proper season pick all the small fruits and vegetables. There are also large classes in basketry, plain and fancy sewing and embroidery under the instruction of the industrial teacher.

In correspondence with various public institutions in the United States and Canada, I have had nearly 100 replies to letters of inquiry concerning the extent of the colony system. These replies show that in 1912 farm colonies were in operation, either independently or in conjunction with the parent plant, in Alabama, Connecticut, Georgia, Illinois, Iowa, Idaho, Kansas, Louisiana, Massachusetts, Minnesota, New York, Ohio, Oregon, Pennsylvania, Utah, Virginia and Washington, as well as in the provinces of British Columbia, New Brunswick and Ontario.

The State of Massachusetts has seemed to be the most active in extending this system.

The Gardner State Colony, at Gardner, Mass., is located on a tract of 1650 acres of land and has 670 patients.[1]

Another large colony of 600 patients is connected with the Worcester State Asylum. It is located on a tract of 900 acres, situated some eight miles from the main institution, on the line of the Boston and Albany Railroad. The patients are cared for in detached buildings. These buildings are grouped with reference to economy in maintenance and administration. The men are engaged in the different farming operations, such as digging, trenching, road making, etc.

Dr. E. V. Scribner, superintendent of this institution, mentions in his letter a somewhat interesting departure in furnishing out-of-doors occupation for incorrigible, refractory women patients. To quote his words:

> I at first set this women's crew at taking care of the grounds, tending flower beds and doing the lighter operations of farming. While I was looking around for further useful occupations they solved the question for me by voluntarily taking up the work of excavating and filling in around our buildings and doing a great variety of the work that the men had formerly done. I am now of the opinion that wherever there is work for the men there is work for the women.

Other small colonies are operated in connection with the state hospitals at Taunton, Danvers, Monson, Medfield, Foxborough and Westborough.

Ohio has a small colony connected with the Massillon State Hospital.

The Oregon State Hospital has a colony of 300 patients five miles from the main institution.

Minnesota maintains two state asylums for the chronic insane on the cottage plan, where farming is the chief occupation. One of these is at Hastings and another at Anoka. One of them is set apart for male patients and the other for female patients.

There are several small colonies connected with the various New York hospitals, the largest one being a part of the Hudson River Hospital. It is especially interesting and noteworthy that there are summer or vacation camps connected with the Buffalo[2]

[1] See Gardner State Colony.

[2] The Buffalo Camp at Wilson, on Lake Ontario, has been given up because of the change of ownership of the property.—ED.

and Rochester state hospitals, located on the banks of Lake Ontario, and one on the Susquehanna River, operated by the Binghamton State Hospital.

The last Legislature of Kansas authorized the building of a new hospital for the insane on the colony plan.

The Clarinda State Hospital, of Iowa, has a colony of 50 patients on a farm of 307 acres named Willowdale, one and one-half miles from the main building.

The East Louisiana Hospital maintains a colony of 80 patients, all males, on a tract of 90 acres. It contemplates erecting three buildings in the near future. The Central State Hospital at Petersburg, Va., has a farm colony known as Ashleigh Grange, which is practically self-supporting, and also one known as Norburne, used exclusively for tuberculosis patients.

The Georgia State Sanitarium maintains a colony of 100 negroes on a farm of 600 acres. This colony not only pays its own expenses, but contributes considerably to the support of the main institution.

The largest colony in Canada is connected with the New Westminster Hospital, British Columbia. It is five and one-half miles from the main institution on a tract of 1000 acres, 600 of which have been cleared by the patients' labor since 1907. When completed this colony will accommodate about 560 patients. The institution obtains from this farm all its milk, part of its butter and all of its vegetables.

Other institutions mentioned are "trying out" the plan on a smaller scale with satisfactory results. Since the beginning of the nineteenth century there has been a growing tendency toward the segregation of the insane by breaking away from the corridor or block plan of construction and adopting a system which will better subserve the purpose of economy and proper classification, in order to promote their improvement and comfort. The colony, the cottage and the boarding-out systems are but different methods of seeking the same results. Scotland has extensively employed the boarding-out system and in 1900 about 23 per cent of her insane patients were cared for in this way. The chief advantage in this system is economy in maintenance and greater contentment of the patient. Experience seems to have demonstrated that patients once established in homes had no desire to return to asylum life.

To my mind the most valid objection offered to the plan is one that should condemn the whole system, namely, that constant association with the insane has a demoralizing effect upon the sane, especially the young; and the protection of society is of as great importance as the care of the insane.

The grouping of cottages about a main building has the objection that it is difficult or impossible by this plan to eliminate institutional features.

The colony plan is too old to be considered an experiment. It is steadily growing in favor in foreign countries and in America. At Alt Scherbitz, near Leipzig, is an institution which has been conducted entirely on the colony plan since 1867. Kraepelin in 1899 said:

> The construction of asylums has experienced extraordinary progress of late years by the evolution of so-called farm colonies in which patients are, as far as possible, given liberty and occupation in country pursuits. The whole question of the care of the insane for a long time has probably found its solution in this best and relatively cheapest method of support.

Personal experience with the method, very imperfectly elaborated, and extending over a period of nine or ten years, has convinced me that it is the best plan yet devised for the treatment and care of at least 60 per cent of our insane for the following reasons:

Of all the therapeutic means at our command in the treatment of the insane, suitable occupation is entitled to the first place. By suitable occupation I mean work and healthful surroundings, preferably in the open air, so directed and prescribed as to meet the individual needs of each case. The aggregation of a large number of persons in one building tends to the specialization of labor, which is not conducive to the complete development of the individual. The work is done automatically and furnishes no incentive to mental stimulus. The individual is lost sight of. The main object is to get the work done. The colony system provides each individual with a great diversity of occupation of such a character as to stimulate and to bring into healthy action all mental faculties. The intelligence with which many colony patients assume and perform responsible duties is extremely interesting. In getting statistics for a paper on this subject, published in 1900 in the *American Journal of Insanity*, I found that of the male population at the Kalamazoo State Hospital by a very conservative estimate 30 per

cent were able to work and could be trusted in open door cottages; 17 per cent of these, or 5 per cent of the total male population, were capable of planning work and directing the labor of others and keeping records, etc., in fact of doing any kind of work that was required of attendants who had charge of them; 15 per cent could work well and intelligently under the direction of other patients and the balance required closer supervision. These facts suggest that 25 to 30 per cent of our entire population is capable, under the direction of a physician and general supervisor, of successfully conducting a farm colony with no other supervision whatever.

The colony plan is more economical if properly conducted. Food may be served in greater variety and with less waste and less per capita expense than where large numbers are massed together and fed from the common kitchen. This is not mere theory or guesswork. I have demonstrated it by actual experience and figures. Furthermore, with diversified and intensive farming, scientifically planned and carried on, labor becomes more remunerative than in the usual pursuits at large institutions. There is always a ready market in the institution itself for everything that is raised on the farm.

The utility of the colony system is not limited to quiet, able-bodied, trustworthy patients as is generally supposed. Experience has demonstrated that farm work and out-of-door pursuits are as well adapted to the disturbed as to the quiet class. The colony system affords a rational plan for the treatment of able-bodied insane epileptics. Their removal from the wards relieves other patients from a great source of distress and the colony plan affords the best facilities for proper diet and the regimen so essential in treating this class of patients.

It is not feasible or economical to operate a colony at a great distance from the parent institution. For this reason colonies in connection with many of our American institutions are often impracticable. Either land near them is not available or is available at so high a price that the economical features of the plan are destroyed. Preferably the whole institution should be located on a single large tract of land, consisting of not less than one acre to each patient. It is impracticable to operate a colony at a greater distance than three miles from the parent institution.

The colony system is practicable; it is capable of a much higher degree of development, and it meets the needs of a much greater percentage of cases than was formerly supposed.

The ideal institution for the insane should have a hospital for acute curable cases, an infirmary with special equipment and trained nurses for the care of the sick and helpless, and a farm colony with homelike cottages and surroundings, where all the healthy, able-bodied chronic cases, including the refractory ones, may be trained in pursuits that are healthy, educative to the patient and remunerative to the institution.

V.

STATE CARE.

State care is now definitely understood to be the care of the dependent insane exercised by the state as state charges, not in any way under the care and management of county or town officials. Formerly state provision, generally speaking, meant a state institution established and built by the state and managed by state officials, whose expenses were paid by taxpayers or by individuals. Thus, for example, the Williamsburg State Hospital in Virginia, when built by the state in 1773, was placed in the hands of a so-called Court of Directors, who were absolutely in charge of it and who managed it as an independent, self-perpetuating corporation. The same state of things existed at the present South Carolina State Hospital at Columbia, S. C. It was supported by those who sent patients to it, whether counties or individuals, until about 1872, and was not a state-controlled institution, according to the present understanding of the term, until after that date.

Similar conditions were present at Utica, N. Y., where private patients were received at the expense of their friends, relatives or guardians and indigent persons were received at the expense of the counties in which they had a legal residence. In other states, as in Michigan, whose first institution was modelled almost wholly upon that at Utica, N. Y., state care was carried out along the same lines. In short, the insane were regarded as wards of the county and were supported in the state institution by different counties, to whose treasurers bills were rendered quarterly for the support of all indigent patients.

At present, the phrase *state care* does not mean a state aided institution or an institution for the care of acute or chronic cases, but the care of all the insane in the state, in institutions maintained by the state under the management of state officers and appointees. There is an important difference between state care as thus understood and state support for a limited number of insane in a state hospital, with the majority of the dependent insane in county almshouses.

The advantages of state care, as it is now understood, are obvious, since the welfare and well-being of the patients become the first consideration, as the only object to be sought by institutional treatment. Under county care there was danger of as many methods of care and of devices for economy as there were institutions. Broad, comprehensive plans for the betterment of the insane, their care and their cure were impossible as long as the custody of patients was placed in the hands of inexperienced persons, like county commissioners or boards of supervisors, or overseers of the poor. These men, as a rule, had an eye single to the taxpayer, and to the possibility of achieving a local reputation for economy. Moreover, in many instances, an opportunity for minor patronage was thus afforded to county officials, by which their political prospects might be increased and their personal importance to their communities enhanced. It is unwise to give men of this type the responsibility of determining whether or not a patient shall be sent to a state institution or retained at home in a county establishment, whose sole advantage is a greater economy, and the unwisdom of this course became apparent when an attempt was made to do away with county institutions. They possessed an influence which extended throughout every portion of the state; and it proved a difficult task to eradicate the mistaken idea that economy was the prime consideration in the care of the insane and irresponsible.

The experience of the hospital at Utica demonstrated the futility of the original idea that a single institution in a central part of the state was sufficient to care for all its insane, because in practical operation county institutions and receptacles in connection with almshouses (where the insane were neglected to a degree which almost staggers the imagination) were invariably established to receive chronic patients removed from the central hospital to make room for cases of recent disease, which were presumably curable. The deplorable history of the original attempt to found a single small institution for the care of the insane of the whole state is yet to be written. There is no more sorrowful chapter in the history of mistaken philanthropy than that furnished by the experience of New York and other states where this idea prevailed.

The first effort to build a state institution was at Williamsburg, Va. This was erected not for the dependent insane alone, but for all classes. The second attempt was at Columbia, S. C., and here

also both pay and indigent patients were received, the latter for about 40 years at the expense of the counties in which they resided.

The first state institution exclusively for the pauper insane was at Worcester, Mass. It was built by the state for the care of the dependent insane and placed under the charge of Dr. Woodward, who had been formerly connected with the Hartford Retreat.

The next state institution in point of time seems to have been that now known as the Utica State Hospital, opened in 1843, which has probably had a greater influence upon the erection of other state institutions than any other single establishment. As has been previously stated, at Utica the state seemed to be simply a landlord or manager acting for the benefit of counties and individuals, who paid alike for the support of patients. In Ohio the hospitals originally established at Columbus and Cleveland were more nearly state institutions, as they were built by the state and supported by it, all patients being admitted at the expense of the state, whether indigent or otherwise. The same conditions obtained in Indiana and Illinois. In these states the rights of each county were recognized, a statute being enacted to establish what was known as a county quota for patients. Fresh cases, however deserving, could not be received from any given county if its quota happened to be filled, nor could a county which had no insane give its quota to any county which needed to secure immediate treatment for acute cases.

Recently, nearly all the newer institutions for the insane in the United States have been established as state institutions. They have not, however, been able to render what we term to-day state care, because they have been inadequate to receive even the acute insane for long. Room for acute and presumably more hopeful patients could only be secured by removing those who had become chronic patients to the county house or receptacle. If any chronic patients were retained by the state, there was generally a strong feeling among those whose friends had been excluded that favoritism had been shown. In New York at one time the period during which a cure was supposed to be effected was 13 months and all persons who had been in the institution during such a period of time could be removed to make room for other patients. In many instances, however, such removals did not take place, as the friends

of chronic patients were often influential and made appeals to boards of managers which could not well be refused.

It is interesting to consider the conditions which eventually brought about the conviction in the public mind that state care as it is now understood was a necessity.

The neglect and abuses in the care of the chronic insane. whether in almshouses, under the charge of county commissioners, or in towns under the charge of selectmen, as in New England, were found to be many and grievous. The lack of any definite scheme of care was apparent everywhere and the necessity of placing insane people in jails, or pens, or loathsome county receptacles became increasingly repugnant to the public mind, until at length the feeling that the state should take care of all of its insane, without regard to residence or to the opposition of local economists in the various counties, became irresistible.

The rapid growth of new states like California and many of the Western states, which at first had no efficient county or township organization, rendered it essential to establish institutions directly under the control of the state. This was especially true in those states to which the insane and the irresponsible had been attracted by mining, or lumbering, or similar primitive employments, and communities found themselves overburdened by the insane without the slightest facilities for their care and management.

In the older states it was found that county and township organizations often served their purposes inequitably in undertaking the care of the insane. In Massachusetts, for example, the towns which had lost their enterprising citizens, through emigration to newer sections of the country, were overwhelmingly burdened by a residual mass of chronic insanity in the state hospitals which, under the law, was still chargeable to the town. This condition finally became so serious that it could no longer be borne by impoverished and struggling hill towns or towns containing many abandoned farms inhabited by aged, feeble and helpless people who were too old to become pioneers in newer and more prosperous regions. State care and state support for the relief of these communities were absolutely essential.

Development of State Care.

The development of state care was slow and in every one of the older and more conservative states was attained only after severe struggle. In New Hampshire the act legalizing state care was passed only a few years ago and did not become operative until 1913. In Maryland, although the act was passed a dozen years ago, full care has not yet been attained. In New York, after many attempts to meet the problem of the insane, first by the establishment of an institution for the chronic insane at Willard and Binghamton and later by new institutions at Middletown, Poughkeepsie, Buffalo and Ogdensburg, as well as by institutions for the criminal insane at Auburn, and later at Matteawan and Dannemora, the question of state care continued to be persistently agitated, and in 1895, after several abortive attempts, a bill was finally passed which established state care for all the insane of the state. This bill required the addition of several institutions and a division of the state into districts in order to provide for patients of the acute and chronic classes at home. The adoption of state care by the State of New York unquestionably gave great impetus to the movement, which has since spread to other states with comparative rapidity.

The best development of state care is in New York. It is the only state where it is carried out without any reference to county hospitals. The state must provide for all cases of insanity wherever developing and jails and poorhouses cannot be used for the custody of the insane.

VI.

THE WISCONSIN SYSTEM OF COUNTY CARE.

The so-called Wisconsin system of county care of the chronic insane, modified forms of which are in force in New Jersey and Pennsylvania, had its origin in a law passed by the Legislature of Wisconsin in 1881, it is said at the suggestion of Andrew E. Elmore, then president of the State Board of Charities, which provided that, with the consent of the State Board of Charities and Reform,[1] any county could purchase a site for an asylum for the chronic insane, and erect buildings thereon for their care, pursuant to plans, drawings and specifications approved by said board; and levy taxes and issue bonds to defray the cost of such site and buildings, and of furnishing and maintaining them. Asylums thus established were to be governed by a board of three trustees, one retiring each year, chosen by the Board of County Supervisors. They were to receive as compensation for their services $3 a day and mileage. No member of the Board of Supervisors was eligible for the position of asylum trustee. To such an asylum all inmates of state institutions for the insane committed from or belonging to the county and held as chronic or incurable, all insane inmates of the poorhouse, and all other persons belonging to or residing in the county, adjudged to be insane according to law and who might properly be confined in an asylum, could be transferred. Each county caring for its own chronic insane in an asylum was entitled to receive a stated sum per week for each person cared for.

The Wisconsin system can hardly be regarded as one thought out from the beginning. Its origin seems to have been an accident that grew out of the exigencies and pressing necessities of the situation in existence when it was established.[2]

[1] In 1891 the State Board of Charities and Reform and the State Board of Supervisors were merged into one body known as the State Board of Control, having all the powers and duties of the two other boards which it superseded.

[2] Burr, C. B., M. D., "Visit to the Wisconsin County Asylums." American Journal of Insanity, Vol. 55, p. 286.

In 1875 the population of the state was 1,236,729; the estimated total number of insane, 1732; the number under care in the two state hospitals at Mendota and Winnebago was 651, leaving 1081, or over 62 per cent, uncared for.[1]

Some provision was necessary to care for this constantly growing class of unfortunates, other than that supplied by the jails and poorhouses of the various counties. Inasmuch as the cost of providing and maintaining hospitals under the control of the state, similar to those erected by other states, was large, the State of Wisconsin was unwilling to make further similar efforts in the direction of state care.

In 1880 the Milwaukee County Hospital, which was designed to receive patients from that county only, was already established. This was what may be called a semi-state asylum, as both the state and Milwaukee County contributed to its support. It received both acute and chronic cases, and, in conjunction with the two state institutions already referred to, offered the only accommodation to the insane of the state other than that provided by county almshouses, until the year 1881, when the law already referred to was enacted, and the State of Wisconsin became definitely committed to the policy of a county care of its chronic insane.

Under the law as amended, upon the completion of a county asylum and its approval by the State Board of Control, a certificate of that fact, signed by its president and secretary, being filed with the secretary, each county so caring for its chronic insane under rules prescribed by the board receives from the state $1.75 per week for each of its own patients, and $3.50 per week for patients belonging to other counties.

The State Board of Control has authority, whenever in its opinion any county has not made provision for the proper care of its acute or chronic insane, to direct the removal of either class to the asylum of some other county possessing suitable accommodations for them; the expense of such removal is borne by the county to which such persons belong; and any county whose asylum can accommodate a larger number of chronic insane than are resident therein, may receive such insane persons as may be removed thereto under the direction of the State Board of Control.

[1] Bullard, Ernest L., M. D., "The Wisconsin System of County Care of the Chronic Insane."

The county asylums created under the Act of 1881 are usually located on farms of over 300 acres, within a mile or so of a city or good-sized town. They are now 35 in number. The number of patients varies from 68 to 239, the average being about 150 persons.

The trustees exercise the powers usually vested in trustees of charitable institutions; they appoint the physicians and the superintendent. The character of the officers selected varies greatly according to the public sentiment of the locality ministered to. The county chronic asylum of Milwaukee, for example, employs a resident medical officer and an adequate number of day and night nurses. This cannot, however, be taken as evidence that the same or equal care is given in the average county asylum. The early asylums in fact were such in name only, the pauper and insane being cared for in one and the same county building. Even after 17 years of trial the basis of care was thought by a competent observer to have continued much the same as that of the poorhouse.[1]

According to Dr. Richard Dewey,[2] "the boards governing the counties of the various states have a purely economic function." "Keeping the taxes down" is their chief and proper function, and the only charitable work that naturally comes to them is the care of the paupers. Insane paupers are apt to be regarded by them as only more unwelcome paupers than the others; and, judging from the measure of care generally meted out to them, less deserving. This is not saying that there are not exceptional institutions under the care of the counties that are well managed, just as there are state institutions that are badly managed, but the rule is the other way, and must be from the nature of things.

"Wisconsin has sought to overcome the disadvantages of county care, and the check upon the parsimony and ignorance of the counties has been in part successful, but something more is needed. No one will deny that enlightened benevolence and special experience are needed by any man, or any body of men, who take charge of the insane."

[1] Burr, C. B., M. D., "Visit to the Wisconsin County Asylums." Journal of Insanity, Vol. 55, 1898.

[2] "County Asylums for the Chronic Insane," read at the 18th meeting of the Wisconsin State Medical Society.

According to Dr. Ernest L. Bullard, in the article already quoted, " although the county, through its appointed trustees, has primarily full charge of and is left unhampered in the administration of the ordinary affairs of the asylum, the state, through the agency of the Board of Control, has all needful authority to enforce its orders in the following particulars:

1. The consent of this board must be obtained before a county may issue bonds or levy taxes for the erection of an asylum.

2. No building operations can be begun until the plans have been approved, and no patient can be received until the buildings have been accepted by the board.

3. No county can receive its per capita allowance from the state until its bills have been approved by the board.

4. If, in the judgment of the Board of Control, a county is not making proper provision for its insane, it has authority to remove every patient to other asylums where better conditions prevail.

Dr. Bullard states that he knows of but one instance of a serious and long-continued disagreement between the state and local boards. This can mean one of two things; either the standard of county care is, in practically every instance, equal to that demanded by the State Board of Control, or that the State Board of Control is disposed to allow a latitude in its requirements, depending upon the sentiment of the communities supporting the asylums. That there can be practical and efficient supervision by a state board far removed from an institution is doubtful, especially when such a board is made responsible for the administration and supervision of all the state institutions. The very number of these asylums precludes any chance of very diligent supervision by the State Board, and certainly in the majority of instances the sentiment of the community of location must be the deciding factor in the quality of care given. Local standards of care will inevitably obtain in spite of central supervision.

The asylums, with the exception of the Milwaukee County Asylum, at Wauwatosa, which has a medical superintendent, are in charge of laymen as superintendents. There is also a matron, frequently the superintendent's wife; their combined salaries amount to from $2000 to $2500 a year. There is a visiting physician, whose average pay is $350 per year.

The State Board of Control on April 5, 1900, issued instructions that:

> Asylum physicians should not be selected and contracts for the medical care of the insane awarded upon competitive bids; the trustees should appoint some competent physician and fix his salary. The selection should be made with the care and consideration that might reasonably be expected in the selection of a family physician.

The physician is supposed to make visits twice each week and attend to a large number of medical details, the sanitary condition, the health, diet, clothing, cleanliness of the patients, the amount of work required of them, etc., but he possesses no authority. All the physician can do is to advise, and his recommendations may or may not be carried out.

In a majority of the older asylums bathing and sanitary facilities are inadequate, to say the least. In practically all of the asylums facilities and arrangements for suitable classification are lacking.

In the county asylums it is claimed that 30 per cent of the patients work all day; 20 per cent work one-half day or more; and 23 per cent do some work. Inasmuch as the range of occupation is practically confined to farm and household work it is difficult to see how the patients manage to occupy themselves during the winter months, since employment in other industries is practically unknown. No efforts are made in the direction of entertainments, except in a few of the more enlightened institutions, where weekly dances are held. There is also practically little effort at ornamentation of grounds and buildings, the ideas of those in charge seeming to be developed along strictly utilitarian lines.

For the 100 to 200 patients generally cared for in these institutions, there are provided about four attendants, and as a rule two night nurses. Patients are left alone much of the time, it not being the aim of the system to give patients constant supervision. In a majority of the cases patients receive night attention from nurses of their own sex.

Dr. E. L. Bullard states that among the features to be commended in these relatively small county asylums are:

1. Greater personal freedom.
2. A nearer approach to the home life of the patients.
3. The excellence and abundance of the food.
4. The greatly reduced cost of maintenance.

As the bookkeeping methods in vogue in the different county asylums vary greatly, the statistics of the per capita cost of caring for the inmates possess but little value. The per capita cost is, however, unquestionably lower than it is in the larger state institutions of Wisconsin and elsewhere; this question of "cheapness" being one of the strongest arguments of the partisans of the system.

A prime objection to such a form of care of the chronic insane, to say nothing of acute cases of insanity, is that its standard is established by the requirements of other inmates of the almshouse and is custodial rather than hospital in character. It varies according to the traditions of the place and the personality of the superintendent and does not possess any uniform or settled principles. There may be as many systems of care as there are asylums. The central unifying principle is economy and not the requirements of persons who are afflicted with a chronic mental disorder. The majority of the superintendents are very generally men who are interested in the work of the farm, and are anxious to make a good financial showing. The superintendent may be kind and considerate of his charges, especially of those who, through physical or mental disability, ought not to attempt severe physical labor, or he may be a forceful, energetic driver who desires to attain results and may sacrifice the permanent good of his patients.

It is evident that the tendency of the system is to convert the state hospital into an institution for the custodial care of the untidy, violent, turbulent and uncomfortable patient of the chronic class who cannot be kept in a county asylum without increased expense and trouble and to cease to use it for the medical treatment of acute and hopeful cases. All are familiar with the fact that local institutions for the custody of the insane always attract to themselves early and presumably curable cases especially of the quieter sort, whose relatives may shrink from sending them a long distance from home and who are hopeful that the mental aberration may prove to be temporary. Under such circumstances the hopes of recovery of such patients may be destroyed by the delay. If state hospitals could be used for the curative treatment of patients exclusively or largely and the county institutions were utilized for chronic cases exclusively of every class, the evil would not be so great, although it is probable that the expenses of the county asy-

lum would be materially increased. It has been asserted in fact by those who are familiar with the situation that many of them are now maintained upon a scale of too great economy and that the sum received from the state is more than sufficient to pay all the expenses of the asylums.

According to Dr. D. Hack Tuke,[1] who was disposed to regard the scheme with favor:

It is very clear that the success of the system requires constant care in the selection of cases, so as not to place in these small county asylums, where there is no resident doctor, acute and curable cases requiring constant medical care. I believe that, among the chronic insane, there is, as a matter of fact, very little selection of cases, probably too little. The superintendents of the state hospitals furnish the lists of chronic insane which are to be returned to the counties. They will, of course, retain the best cases, and sometimes send unsuitable ones to the county asylums. Occasionally the counties return a homicidal or filthy patient. Otherwise they have so far taken all the chronic cases from their own counties, who usually are the worst treated, and therefore, probably, the worst behaved, insane inmates of almshouses.

The appointment of similar able and well-intentioned men on the Board of Charities, as well as of thoroughly reliable masters, is also essential to success. Otherwise there will inevitably be a return of the evils from which the insane in the old almshouses have escaped.

The objections to the system have been stated by Dr. C. B. Burr,[2] as follows:

1. Absence of the hospital idea.

2. Lack of medical oversight.

3. The inadequate care of patients, particularly of the filthy and feeble classes and epileptics.

4. Lack of sufficient attendants, which necessitates patients remaining too much indoors, particularly in the winter time.

5. Lack of standards of care prescribed and enforced by central authority, superior to politics, as shown in the extreme variation in per capita cost and differences in beds, furnishings, attendance, etc.

6. Lack of efficient state supervision.

7. Frequent lack of discriminating local supervision, this due chiefly to absence of knowledge of the requirements of the insane and the desire to make favorable financial showings to boards of supervisors.

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[1] The Insane in the United States and Canada, London, 1885, p. 88.

[2] "A Visit to the Wisconsin County Asylums," American Journal of Insanity, Vol. 55.

On June 30, 1912, the total insane population of Wisconsin was 6855, of which number, 5016 were in the county asylums.

In a subsequent volume, in a chapter dealing with the care of the insane in Wisconsin, copious extracts have been given from a paper by Ernest L. Bullard, M. D., several times quoted in these pages on "The Wisconsin Care of the Chronic."

CHAPTER V

GOVERNMENT AND MANAGEMENT OF HOSPITALS ARCHITECTURE

I.

EVOLUTION OF THE ADMINISTRATION OF HOSPITALS.

The first managing boards of hospitals for the insane had a variety of titles. In Virginia they received the rather formidable designation of Court of Directors; in Maryland and the District of Columbia they were called Visitors, and in New York Managers, while in most of the states they were denominated Trustees. In corporate institutions they were, in theory, a committee representing the subscribers and were charged with the immediate management of the affairs of the institution. In state institutions they acted as representatives of the commonwealth. They were, as a rule, selected by the Governor from among the best citizens, being chosen, not for their philanthropy alone, but for their business ability and experience in affairs. They received no pay other than their necessary expenses in the discharge of their official duties, because their service to the state was so valuable it was manifestly impossible to reward it by any adequate salary. It was also feared that if a nominal salary, however small, should attach to the position of manager, such salary would attract men of less desirable character to become applicants for appointment. It is most creditable to the high-minded philanthropy of the public-spirited men who thus served the public to recall that they gave gratuitously to the state a grade of service which could not be paid for. In some cases they spent many days each year in supervising the work of the institution committed to their care. In the early history of the Friends' Asylum at Frankford a dissatisfied patient on his discharge after his recovery from an attack of melancholia sued the directors of the asylum and recovered $15,000 as damages, which sum was paid out of the private funds of one or more of the directors and not out of the asylum treasury.

At the Vermont Asylum at Brattleboro, now known as the Brattleboro Retreat, the trustees gave most valuable personal service to the institution; they selected and bargained for lands in a rural community, made estimates for buildings, drew contracts and looked after all details of building as carefully as in any private

business, although forbidden to receive any salary by the terms of the will under which they had been appointed.

Gradually, however, as institutions grew older, it became more and more convenient to entrust the whole management to an able superintendent. In this manner were developed men like Wyman, Kirkbride, Ray, Earle, Brigham, Gray, Bancroft and others. This development of strong men, who were willing to assume responsibility, was advantageous in certain ways because each institution thus secured the initiative of a forceful, self-sacrificing and enthusiastic personality. This explains in some measure the tone of "extreme philanthropy" which has been said to characterize the early reports. They were written by men of devoted character who, like Miss Dix, were persuaded that the care of the insane was a sacred calling which required the best energies of their minds and hearts. They undertook the task of arousing indifferent or hostile communities and commonwealths to action in a spirit of the purest philanthropy. The disinterested zeal of these able men was an important agent in bringing about the earlier provision for the neglected insane in many states.

After the first glow of enthusiastic effort in behalf of the insane had passed and the control of institutions had come to be regarded as one of the perquisites of a dominant political party, there developed some hitherto unsuspected disadvantages in this method of government. Local influences displayed in the matter of purchases, in the deposit of the money belonging to the institution in local banks, in local pressure for the employment of residents of the immediate vicinity who happened to belong to the political party then dominant, all began to make themselves felt. These, in turn, influenced the type of men selected to occupy the position of superintendent.

This political trend finally resulted in the decline of the system and the substitution, first, of paid boards and ultimately, in many states, of boards of control. Paid boards were instituted because political appointees often felt that their services must be rewarded by something more substantial than a purely honorary appointment. To furnish a suitable salary for each member of a large board seemed an extravagance to rural legislators and boards were consequently decreased in size before salaries were attached to membership in them. The units in the divisor being diminished,

the resulting quotient of salary for the fortunate men who received appointment became greater. In order to increase the salaries paid to such boards, politicians conceived the happy thought of reducing their number and concentrating the control of institutions in a single board. The next step was an easy one, viz.: to concentrate the government of all the charitable institutions of a state in a single board which should make a business of charitable administration. Hence hospitals for the insane and institutions for the feeble-minded, schools for deaf and blind, orphan asylums, reform schools, penitentiaries, and, in one state, normal schools and universities, were all placed under a single board. The favorite number for membership has generally been five persons, although several excellent boards of control have contained but three members.

In certain states a similar effort to do away with boards of trustees or managers resulted in the establishment of institutional control by a lunacy commission. At first boards of state charities performed the duty of inspection, sometimes as a body or through a committee, but more generally through a secretary. Control was thus sometimes exercised in the matter of appropriations. Almost every state provided that when appropriations were desired they should be approved by the Board of State Charities, after an inspection of the institution and full consideration of its needs. The Board of Charities in too many instances found its recommendation disregarded by the Legislature charged with the responsibility of appropriating or withholding money. Frequently appropriations were made which were frowned upon by the Board of Charities or else appropriations which were considered essential to the welfare of the institution were not made. Moreover, there grew up the feeling that too much labor devolved upon the boards of state charities, so that in New York, Massachusetts and, to a limited extent, in Pennsylvania their duties were finally limited to the inspection of almshouses and jails, asylums for children, institutions for the feeble-minded, county receptacles for the insane, and the soldiers' homes. The duty of inspecting state institutions for the insane was assigned to a Board of Insanity, as in Massachusetts; to a Commissioner in Lunacy, as at first in New York, or to a Committee in Lunacy, as in Pennsylvania. The first Commissioner in Lunacy in New York, appointed as a result of

the provisions of the law of 1873, was Dr. John Ordronaux. He was succeeded by Dr. Stephen Smith, who in turn was succeeded by Dr. Wesley Smith. These men did excellent service, but their functions were confined to inspection and advice, and, with the advent of state care, it became apparent that a single commissioner would not be adequate to discharge the increasing duties required by the state hospitals. Recourse was consequently had to legislation through which the Lunacy Commission was enlarged by the addition of two members to the physician who had previously been the sole commission. The act provided that one of the additional commissioners should be a lawyer and the third a good business man of large experience. It soon became evident to the Commissioners in Lunacy that additional executive powers were needed to render the commission equal to the task imposed upon it. This idea met with much opposition at first, but eventually the views of the Lunacy Commission prevailed, the boards of managers were abolished, and boards of visitors were appointed for the different hospitals of the state. The Lunacy Commission was given ample powers to supervise every portion of the hospitals, to purchase supplies, to appoint and remove superintendents, and to control all details of administration. The effect of this centralization of power has been variously regarded, but there is good reason to believe that, upon the whole, it has made for a more uniform care of patients, better methods of treatment, and increased facilities for scientific and laboratory work. It is of interest to observe that during the past year in New York the pendulum has begun to swing in the opposite direction. Boards of managers have been re-installed and the importance and multifarious functions of the Lunacy Commission have been, to some extent, curtailed.[1] Boards of control of institutions for the insane have been established in many Western states, the most successful being those of Iowa and Minnesota.

[1] The Lunacy Commission in 1914 was re-named a Hospital Commission and its three members were given an equal rank, so that the physician-member had no longer the presidency or any preponderance in salary or influence.

II.

PRESENT GOVERNMENT OF INSTITUTIONS FOR THE INSANE.

A careful analysis of the methods of government of institutions throughout the United States indicates certain differences in the modes of control which have developed in the newer states or have been developed elsewhere from older methods.

It is evident that the early system of control in institutions for the insane was derived largely from the experience of institutions in England, where, in many cases, a board of trustees, or directors, managers, or governors was selected by the annual subscribers to the funds of the institution. The contributors were in the habit of electing representatives to manage the institution and social and other influences probably combined to create a large board. Thus, for example, there might be life members and life patrons who had made large subscriptions and consequently were entitled to be represented upon the board of control in equity or honor. The size of the board thus created rendered it impossible for the directors to meet as a body to manage the affairs of the institution and it became customary to delegate the management to an executive committee, small in numbers and better fitted for executive work.

When the Virginia State Hospital at Williamsburg was built and organized in 1773 a court of directors consisting of twelve members was appointed to manage its affairs and given certain judicial powers. In Philadelphia, in connection with the Pennsylvania Hospital, a board of managers was selected from the annual subscribers, which acted through an executive committee. The same was true of the New York Hospital in New York, with its branch, the Bloomingdale Asylum, which was managed by a committee of the governors of the New York Hospital. Similarly the McLean Asylum at Somerville, a branch of the Massachusetts General Hospital, was under the control of a committee of the board of directors of that hospital. When the Hartford Retreat was established a comparatively large board of directors was appointed in accordance with previous custom, which transacted the business

of the institution through an executive committee. The same was true of the Friends' Asylum at Frankford, founded in 1817. It is apparent that when the state institutions for the insane were established it was but natural to appoint boards of trustees, directors or managers through the central authority of the state, viz., the Governor. For many years this was the form of government adopted for state institutions in nearly all of the United States.

An analysis of different institutions shows that the state institutions in Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Vermont and Virginia are still all under boards variously named governors, managers, visitors, directors or trustees, appointed as a rule by the Governor, and responsible for the management and control of one or more institutions.

The composition of the boards varies considerably in numbers and somewhat in powers, thus:

In *Alabama* a board of seven trustees, serving for seven years, fills its own vacancies and the nominations made by it are confirmed by the Senate. This board elects the superintendent for a term of eight years and may remove him for just cause.

In *Arkansas* for the management of the state institution there is a board of six trustees, appointed biennially by the Governor, one from each Congressional district. This board elects a superintendent for a term of four years.

In *California* there is a board of managers appointed for four years by the Governor for each institution. Each board appoints the superintendent, subject to an examination by the General Superintendent of the Hospitals for the Insane, who is a state officer.

In *Connecticut* a board of twelve trustees is appointed by the Senate, which, with the Governor as an *ex-officio* member, controls each hospital. This board appoints and removes all officers and fixes their compensation.

In *Delaware* a board of nine trustees, three from each county, is appointed by the Governor, to serve for three years. This board appoints all officers.

In the *District of Columbia* a board of nine visitors is appointed by the President. This board serves practically for life and has the supervision of the affairs of the institution, but exercises little more than supervisory control. The superintendent of the hospital is appointed by the Secretary of the Interior.

In *Georgia* the State Sanitarium is under the control of a board of ten trustees, appointed biennially by the Governor, which elects the superintendent and other officers and may remove them for cause.

In *Idaho* a board of three directors is appointed for each hospital, one hospital being served for two years and the other for three years. Each board elects a superintendent to hold office during its pleasure.

In *Indiana* there is a board of four salaried trustees for each hospital, appointed for four years and removable for cause upon written charges. Each board appoints a superintendent.

In *Louisiana* a board of eight administrators for each hospital is appointed for a term of four years by the Governor, who is also an ex-officio member of each board. The board of administrators elects the superintendent.

In *Maine* there is a single board of seven trustees, one of which must be a woman, for the management of both hospitals. This board is appointed by the Governor, with the advice and consent of the council, and holds office during the pleasure of the Governor and council for not more than three years. The board appoints the superintendent of each of the two hospitals.

In *Maryland* each hospital is controlled by a board of nine managers, appointed by the Governor for six years. Each board appoints a superintendent and other officers and has power to remove them for cause.

In *Massachusetts* each hospital is governed by a board of trustees, consisting of five men and two women, with the exception of a single board, which is composed only of seven men. These trustees are appointed by the Governor for a period of seven years. The trustees appoint the superintendent and other officers.

In *Michigan* each hospital has a board of six trustees, appointed by the Governor for six years and removable by him. Each board appoints the superintendent and other officers. A representative from each board of trustees, together with four members of the

board of regents of the University, compose the board of trustees of the Psychopathic Hospital, which is connected with the University of Michigan. The board for the control of the institution for the dangerous insane at Ionia is composed of three members, elected from the boards of trustees of three institutions for the insane in the lower peninsula.

In *Mississippi* a board of trustees of five members, three of whom are physicians, is appointed by the Governor for each hospital for two years. The Governor is *ex-officio* president of both boards. The superintendent is appointed by the Governor for a term of four years and may be removed for cause.

In *Missouri* each hospital is under a board of five trustees, appointed by the Governor for four years. The trustees appoint the superintendent and other officers and may remove all at their pleasure, except the superintendent; the latter may be removed for incompetency or misconduct.

In *Nebraska* two of the hospitals, built primarily for the care of the chronic insane, are under the control of the Board of Public Lands and Buildings. The Nebraska State Hospital at Lincoln has a board of three trustees, appointed by the Governor for six years. The trustees appoint the superintendent and assistant for a term of six years.

In *New Hampshire* the State Hospital had a board of twelve trustees, appointed by the Governor and council and serving without pay. In 1913 a board of control consisting of five members, three persons serving without pay and the Governor and chairman of the State Board of Charities *ex-officio,* was established. This board of control, after two years, was replaced by a board of ten trustees appointed by the Governor and council to manage the penal and charitable institutions of the state. These trustees have varying terms of service and serve without pay.

In *New Jersey* each state hospital has a board of eight managers, appointed by the Governor for a period of five years. Each board appoints a medical director, assistant and warden. A committee of two members from each board must visit each county insane asylum in their respective districts annually and make recommendations in reference to them in their annual report. This seems to be the only instance in a state hospital where a board of trustees appointed to govern an institution is given power of inspection and

advice in reference to other institutions in the district of the hospital.

In *New Mexico* a board of five directors is appointed by the Governor. The board elects the chief executive officer, who, with its consent, employs physicians, nurses, guards and other necessary employes and fixes their salaries. In this institution the president of the board, a layman, evidently exercises the chief functions in its management.

In *New York* each state hospital has a board of seven managers, two of whom must be women, appointed for terms of seven years. The State Hospital Commission, however, appoints the superintendent subject to the approval of the board of managers in each institution. The superintendent of the institution may be removed by a majority vote of the board of managers, provided its action be approved by the State Hospital Commission. The ultimate control of institutions in New York rests with the State Hospital Commission, which, in addition to advisory powers, possesses absolute control in all essential matters.

In *North Carolina* each hospital has a board of nine directors, who serve without pay and are appointed by the Governor for terms of six years. The directors appoint the superintendent for a term of six years. The superintendent appoints all subordinate officers and may remove them for cause.

In *North Dakota* the board of trustees is appointed by the Governor for four years. The trustees in turn appoint the superintendent, the assistant physicians, " guardians," nurses and other employees and may also discharge them at will.

In *Oklahoma* the institutions are governed by a board of three trustees, each appointed by the Governor for three years. Two boards have the power to appoint the superintendent of the hospital, but the superintendent of a third hospital is appointed by the Governor for a term of four years. The trustees have the power to remove all officers and employes.

In *Pennsylvania* state hospitals are controlled by individual boards, consisting generally of nine trustees, appointed by the Governor for three years. The trustees appoint the superintendent of each institution, who is subject to removal or may be re-elected for a term of ten years.

In *South Carolina* the State Hospital has a board of five regents, appointed by the Governor for six years. The method of the appointment of the superintendent is not given, but he is probably appointed by the Governor.

In *Tennessee* each hospital has a board of five trustees, appointed from the district in which the hospital is located for a term of six years. The trustees appoint a superintendent for a period of eight years. The superintendent, subject to the control of the trustees, has entire control of the appointment and dismissal of all subordinates.

In *Texas* each hospital has a board of five managers, appointed by the Governor for two years. The managers elect the superintendent and appoint other officers and employees on his nomination and discharge them on his recommendation.

In *Vermont* the State Hospital has a board of three trustees, appointed by the Governor for six years, which board appoints the superintendent, steward, chaplain and matron and other necessary officers.

In *Virginia* each state hospital has a special board of three directors, appointed by the Governor for six years. All the boards of special directors combined form a general board for the government of the state hospitals. The general board of directors meets annually at each hospital and appoints the respective superintendents for a period of four years. The special board of each hospital, subject to the approval of the general board, appoints for terms of four years all other resident officers. The superintendents of the hospitals appoint, remove and employ all subordinates except the resident officers.

It is evident from the above summary that, as a rule, there is a very clear and definite recognition of the principle of the responsibility of boards in the government of most of the hospitals for the insane. Each board is generally appointed by the Governor, with the advice and consent of the Senate, and is made responsible for the management and control of the institution, appointing the superintendent and giving to him certain definite powers, subject to the control of the board. It is interesting to observe, however, that in some states, where hospitals are governed in this manner by boards of directors, the Governor has the power to appoint the superintendent. In New York, as has already been pointed out,

the appointment of the superintendent does not rest wholly with the board of managers, although the board of managers has an implied veto power and also may remove an obnoxious superintendent, provided the State Hospital Commission approves.

It is evident that the boards of trustees of state institutions are at present in a transitional state. There is a tendency to reduce the membership of boards and to give compensation for service. In some states the compensation is ample for the duties performed; in others it is simply a *per diem* rate, with traveling expenses.

It should be observed that where state supervision exists through boards of charities and corrections, little control seems to be exercised over the institution. Where there are boards of control or of administration, however, as in Illinois, Iowa, Kansas, Minnesota, Ohio and other states, the supervision of the institutions seems much more thorough than where the boards possess advisory powers similar to the old-fashioned boards of charities and corrections. It is also interesting to notice how rapidly during the past two decades a tendency has developed toward the establishment of so-called boards of control, especially in the Middle West and the Western states. The boards of control seem in many instances to have been composed originally of state officers, serving *ex-officio,* who had other official duties. In a number of states these *ex-officio* boards are still in charge of institutions. Thus in Arizona, the State Hospital at Phoenix is managed by a State Board of Control, consisting of the Governor, the State Auditor and one citizen appointed for two years.

In *Florida* the State Hospital is governed by a Board of Commissioners of State Institutions, consisting of the Governor and administrative officers of the executive department, who serve *ex-officio.*

In *Montana* there is a State Board of Commissioners for the Insane, consisting of the Governor, the Secretary of State, and the Attorney-General, all serving as *ex-officio* members.

In *Nebraska* two hospitals for the chronic insane are under the control of the Board of Public Lands and Buildings, composed of the Commissioner of Public Lands and Buildings, the Secretary of State, the State Treasurer and the Attorney-General, who serve as *ex-officio* members.

In *Nevada* the State Hospital is under the control of a board of commissioners, consisting of the Governor, the State Treasurer and State Comptroller, who serve as *ex-officio* members.

In *Oregon* the Board of Trustees, as it is called, is composed of the Governor, the Secretary of State and the State Treasurer, who serve as *ex-officio* members.

In *Utah* the Board of Insanity is composed of the Governor, the State Treasurer and the State Auditor, all serving as *ex-officio* members.

In *Wyoming* the State Hospital is controlled by a State Board of Charities and Reforms, consisting of the Governor, the Secretary of State, the State Auditor and the State Superintendent of Public Instruction, all of whom serve *ex-officio*.

It will be noticed that nearly all the states in which these *ex-officio* boards exist are small, with comparatively limited hospital facilities and without a great burden of responsibility in their management. It is to be feared that boards composed wholly of *ex-officio* members cannot be very efficient, because of a division of interest and the lack of any stimulus to improvement.

Institutions under the control of *ex-officio* boards are apt to be managed either by professional politicians or else by one active member, with an eye to his re-election or his political aggrandizement, and with little regard to the good of patients.

As a result of the success which attended the boards of control appointed originally in Wisconsin and Iowa and afterwards extending to other states, there is now a definite policy on the part of many of the Middle Western and Western states to provide for the government of institutions for the insane by a separate body charged in some cases with the duty of caring for the insane alone and in others with the control of other charitable institutions.

In *Colorado* such a board, which is known as the Board of Lunacy Commissioners, consists of three members, appointed by the Governor for a period of six years, with an adequate salary.

In *Illinois* the board is known as the Board of Administration and consists of five members, appointed for a period of six years, with salary.

In *Iowa* there is a Board of Control consisting of three members, appointed for six years, with salary.

In *Kansas* the central board, which is known as the Board of Control of State Charities, consists of three members, appointed for a period of four years, with salary.

In *Kentucky* the board is known as the Board of Control, and consists of four members appointed for four years, with salary.

In *Minnesota* the duties of the board are much enlarged. It is known as the State Board of Control for all Charitable Institutions. It consists of three members, appointed for a period of six years, with salary.

In *Ohio* the board is known as the Board of Administration. This board also has enlarged powers and manages all state institutions. It consists of four members, appointed for four years, with salary.

In *Rhode Island* the state institutions are managed by a Board of State Charities and Corrections, consisting of nine members, appointed for a period of six years. Although this board is not so denominated in the act, it performs duties of the same kind as other boards of control.

In *South Dakota* the institutions for the insane are managed by a State Board of Charities and Corrections, consisting of five members, appointed for a period of six years.

In *Washington* there is a State Board of Control, consisting of three members, appointed for a period of six years, with salary.

In *West Virginia* there is a State Board of Control, consisting of three members, appointed for six years, with salary.

In *Wisconsin* all the affairs of the insane are looked after by a State Board of Control, consisting of five members, one of them a woman, appointed for five years, with salary.

The statement has already been made that largely owing to the influence which governed the organization of the state hospitals in Massachusetts, Vermont, New Hampshire and New York, boards of trustees managed the institutions in behalf of the state, as separate corporations. Many institutions followed with a similar organization. As a rule the trustees, directors, managers, regents or governors, whatever they were called, were appointed by the Governor of the state, by and with the advice and consent of the Senate, and sometimes without it, as is the case in Massachusetts.

No thought of political control or political influence entered into the original boards of trustees. The trustees were appointed

because of known reputation and business ability and were expected to attend to the affairs of the institution with an eye single to the prosperity and success of the institution.

In the earlier days they served without pay, and they gave an amount of time and service to the affairs of the institution which could not have been adequately rewarded by any salary, because they brought a higher degree of experience and ability than the state could afford to reward. They were judges, lawyers, physicians, bankers and business men, all of them leading busy lives. Later on, after the lapse of years, as the system extended to some of the newer states, political influences crept in. In Ohio, for example, it soon became the custom to change the board of trustees whenever the political parties in that closely divided state changed places. Upon the election of a Democratic Governor in 1877 an edict went forth that the superintendents of the state institutions must be in "harmony," as it was expressed, with the political views of the Governor. This edict especially affected Dr. Richard Gundry, a distinguished and able superintendent, who had planned, managed and built several institutions for the insane in that state during an active service of many years. Dr. Gundry had served 23 years faithfully, without partisanship, and most efficiently, and there seemed little necessity for such "harmony," since the Governor was elected for a single year. Such, however, was the edict. He was accordingly removed from office (as were also all others in the institution of similar inharmonious political faith) and compelled to seek another institution in a distant state. Similar overturnings took place in Missouri, Virginia, Illinois, Indiana, Kansas, Texas and Washington as the result of political changes. The most flagrant instance of such a perversion of the purposes of a charitable institution took place in the State of Kansas, where a mushroom political party sprang into existence and speedily fell into deserved oblivion. Every person connected with the State Hospital at Topeka was removed and a new superintendent, physicians, nurses, orderlies, maids, cooks, farm hands, teamsters and day laborers were brought in, because they were in "harmony" with the new party. One hospital for the insane in Ohio was reputed to have had 12 superintendents in 11 years and other states suffered similarly, though not so intensively. The list of states which thus dishonored themselves is a long and sad one.

In some states it was customary to appoint trustees from certain specified districts, with a preponderant number from the county immediately surrounding the hospital. In Iowa we learn from a statement prepared some years ago by a former superintendent that a resident trustee was appointed in each institution, to whom were committed many matters connected with the local work of the hospital. He was often made the treasurer, perhaps the chairman, of the executive committee, and was generally recognized as having a predominant voice in all local affairs.

In Michigan two trustees were appointed to reside at the seat of the hospital to act as an executive committee.

Boards of managers or trustees, as a rule, did excellent service in the management of institutions, but there were disadvantages. In some instances the position became a reward for political service, and occasionally, although rarely, there was a suspicion that the local trustee profited by contracts, or by the purchase of supplies, though he probably did not do so directly.

In some instances, where the trustee acted as treasurer, he deposited the funds of the hospital in a bank which he owned or controlled. Recently, in California, a scandal has arisen because of a purchase of hay, an important supply, ostensibly purchased for the use of the institution. Through the collusion of two officers of the institution, the amount of hay paid for through false bills and weights was largely in excess of the amount purchased, the proceeds being divided between the guilty parties. In other instances the trustees interfered in the appointment and discharge of employees and thus exercised a baneful influence upon the discipline and morale of the institution. In more than one state the medical officers of the institutions became actively engaged in politics and ordered their male employees to vote in behalf of one or the other political party. In one instance the superintendent of a state hospital organized a glee club to gladden political meetings with song.

Another disadvantage which grew out of the trustee system was that with several institutions in a given state and the natural rivalry and emulation such as frequently arose between them, individual boards of trustees or committees often visited the legislature to lobby for appropriations to improve their own institutions, with but little regard for the welfare of the whole state. In many

instances, where institutions possessed active lobbyists or enterprising trustees, they secured liberal appropriations and larger sums of money than other institutions.

This frequently gave rise to jealousy and heart-burning between officers, as well as to a waste of public money. Hence it is not strange that in some of the Western states, where evils of this character had existed to a great degree, a movement to establish a central board of control for all the institutions was agitated and became popular. Such a central board of control would view all institutions impartially and have no pecuniary interest in one beyond another. It would consider the needs of the institution in deciding upon improvements, new buildings and additional lands, and be guided wholly by the welfare of the institution. There is a degree of danger, however, that under such a board of control, which stands between an individual institution and the state and exercises unlimited control, all initiative on the part of the officers of the individual institution may be lost. They cannot originate any new policy, nor can they act without the consent of the board of control, which, conceivably, may be governed by motives of economy rather than by a desire to further the good of the institution.

In states like Ohio, Iowa and Minnesota we are assured by those who know that such conditions do not exist. Wise boards of control have allowed institutions to develop in their own way and they have been absolutely free from any political bias in the selection of a superintendent, to whom has been committed, without any restriction, the selection and appointment of employees and their discharge for cause. Such a board of control has been an important factor in regulating the wages of employees and establishing a uniform grade of service throughout the state. It has improved the living conditions of employees, giving them better housing, better food and better living conditions. All persons agree that in Minnesota the condition of patients has been improved. Supplies are bought more economically than was formerly the case and have been standardized so that all patients throughout the state are treated alike. There has been a marked improvement in food, clothing and general surroundings. Many of these betterments have been rendered possible by economies which have prevented waste or careless inspection of food supplies. Political control has

become a thing of the past and institutions are now managed in the interest of the whole state and not of any part of it.

In Iowa we are told that politicians have been wholly eliminated from the hospitals and that in the selection of officers and employees a high form of civil service or merit test has been instituted. There have been economies of purchase and uniformity of accounts, so that the accounts of one institution may be compared with those of others. There also has been an impartial consideration of the actual needs of the institution at the hands of a board of experienced, capable and high-minded men. As a result of this the standard of care has been raised. Greater confidence in the state institutions has also developed throughout the state, because of the confidence placed by the public in the integrity, ability and good sense of the board of control, owing to the fact that it is a central board, responsible to the whole state and not to individuals.

III.

METHODS OF INVESTIGATION OF PUBLIC INSTITUTIONS.

California.

The State Commission in Lunacy consisting of five members, to wit: The General Superintendent of the State Hospitals, the Secretary of the State Board of Health, and the three members of the State Board of Examiners, is authorized to make an investigation of the conduct of institutions for the insane.

When the commission has reason to believe that any person held in custody as insane or incompetent is wrongfully deprived of his liberty, or is cruelly or negligently treated, or inadequate provision is made for his skillful medical care, proper supervision and safekeeping, it may ascertain the facts, or may order an investigation of the facts by one or all of its members. It or the commission conducting the proceedings may issue compulsory process for the attendance of witnesses and the production of papers, and exercise the powers conferred upon a referee in a superior court. The commission may make such orders for the care and treatment of such person as it may deem proper. Whenever the commission undertakes an investigation into the general management and administration of any hospital for the insane or incompetents or places of detention for the alleged insane or incompetents, it may give notice to the Attorney General of such investigation, who must appear personally or by deputy and examine witnesses who may be in attendance. The commission, or any member thereof, may at any time visit and examine the inmates of any county, city and county, or city almshouse, to ascertain if insane persons are kept therein. When complaint is made to the commission regarding the officers of any hospital or institution for the insane or other incompetents, or regarding the management thereof, or of any person detained therein, or regarding any person held in custody as insane or incompetent, the commission may, before making an examination regarding such complaint, require the same to be made in writing and sworn to before an officer authorized to ad-

minister oaths, and on receiving such complaint, sworn to if required by the commission, the commission shall direct that copy of such complaint be served on the authorities of the hospital or institution or the person against whom complaint is made, together with notice of time and place of such investigation as the commission may direct.

Colorado.

The State Board of Charities, upon request of the Governor or of the general assembly, or upon sworn complaint of two or more citizens, or upon its own motion, may make an investigation by the whole board or by a committee thereof of any institution. The board can compel the attendance of witnesses, etc. A report of such investigation, with findings and recommendations, must be filed with the Governor.

Also, upon formal complaint, the board may make inquiry into the conduct and management of private eleemosynary institutions, societies and corporations, and may revoke any licenses granted to such institutions.

Illinois.

The State Board of Administration and State Charities Commission both have power to conduct investigations of public, charitable or correctional institutions, also of institutions caring for children or treating mental and nervous diseases. Investigations may be initiated by either board or conducted in conjunction, at the request of the Governor.

No rules or methods are prescribed for the investigation. Investigations cannot be compelled by extraneous authority, but it is the board's policy to investigate on receipt of any complaint. If newspaper accounts or rumors are of such a character as to warrant proceedings, an investigation is made. If the investigation is at the request of the Governor, a report is made to him; otherwise it is filed in the records of the body making the investigation.

Indiana.

The State Board of Charities in its discretion may investigate penal and charitable institutions either by the board or by a committee of its members. It can compel the attendance of witnesses, etc. A report of the investigation is made to the Governor, and

must be submitted by him with his suggestions to the general assembly.

The board makes such rules and orders for the regulations of these proceedings as it may deem necessary.

Iowa.

The State Board of Control has power to investigate all state institutions under its control and all county and private institutions in which insane persons are kept.

The authority over state institutions carries with it power to correct abuses. Authority over county and private institutions in which insane persons are kept is confined to advisory powers. The Governor frequently orders investigations and appoints committees for that purpose.

No state law prescribes methods of investigation except such as are found in the statutes in regard to powers of the board. The attendance of witnesses can be compelled.

No extraneous authority except the general assembly can compel an investigation.

The report of an investigation containing evidence of witnesses and conclusions of the board must be filed with the Governor.

Kansas.

The State Board of Control is authorized to investigate state institutions on complaint coming from a reliable source, or from any employee of the institution, or from any citizen of the state, when in the judgment of the board the interests of the institution or the welfare of the state demand such investigation. The board can compel the attendance of witnesses, etc. Whenever charges are made by any person or persons and circulated within the state and deemed reliable, notice is to be given to the official concerned and pending the investigation the Governor shall relieve the official from duty.

Maryland.

In Maryland there are two bodies which have the right to investigate public charitable and correctional institutions. First, the State Lunacy Commission has power to investigate institutions which care for persons suffering from mental troubles. Second,

the Board of State Aid and Charities is given power "to make any investigation it sees fit." In addition, of course, the Governor or legislature has power to appoint special commissions.

With regard to the Lunacy Commission, the lunacy laws prescribe methods of procedure. Otherwise there is no state law prescribing rules or methods of procedure.

Massachusetts.

The State Board of Insanity has the right of investigation of institutions for the care of the insane, feeble-minded, epileptic and inebriate. It has the right to investigate questions of sanity and the condition of persons restrained of their liberty. It often acts as a board of appeal in adjusting differences and complaints.

The Governor can order an investigation of an institution and the report of the same must be made to him. No methods of procedure are prescribed in this state for conducting such investigations.

Michigan.

In this state the Board of State Commissioners for the general supervision of charitable, penal, pauper and reformatory institutions is empowered to investigate all such institutions. The said commissioners or either of them shall also make special investigation into any alleged abuse in any of the institutions. They are authorized to visit whenever the Governor shall direct, and a report must be made to him within such reasonable time as he shall prescribe. Also the commissioners, whenever abusive treatment shall come to their knowledge, shall immediately investigate and report the facts of such abusive treatment to the Governor, with such recommendations as they shall deem proper.

Missouri.

The State Board of Charities and Corrections may by its own volition or upon the order of the Governor investigate any public charitable or correctional institution.

There is no legal direction as to the legal procedure during such investigation. Witnesses are put under oath. Outside authorities cannot compel an investigation. When the board investigates of its own motion it ordinarily publishes reports. When ordered by the Governor it reports to the Governor.

New Jersey.

The State Commissioner of Charities and Corrections of New Jersey may, upon an order of the Governor, conduct an investigation of any of the state institutions, and in making such investigation the Governor may appoint two citizens of the state to assist the commissioner. The method of conducting such investigation is not controlled by statute.

No extraneous or outside parties may compel such investigation unless it be the power of public sentiment acting through the chief executive. The report of any such investigation with any conclusions or recommendations resulting therefrom is made to the Governor.

New York.

The Governor of the state has authority under the statutes to conduct an investigation of any institution. Also the legislature may investigate by passing a resolution to that effect; also district attorneys may investigate with the aid of the grand jury where crimes are alleged to have been committed. Formal charges may always be filed and these are carefully investigated by the state board or by the board of managers of the institutions or by both. The state board investigating reports its findings to the legislature as a part of its annual report. If the board of managers investigates it reports its findings to the state board.

The statute in a general way covers methods of procedure, such as calling witnesses, administering oaths, etc.

North Carolina.

The Governor of the state, as chairman of the Board of Internal Improvements, has the power to have any institution investigated and to put witnesses on their oath. This power has been added to the board's duties during the last few years.

The State Board of Public Charities has the right to investigate any charitable or penal institution, but not the right to put witnesses on oath.

Nebraska.

The Governor of Nebraska has sole authority to order an investigation of state institutions or the management of the same. There is no law providing rules or methods of procedure.

Ohio.

Section 1354 of the code provides that the Governor may order the Board of State Charities or a committee thereof to investigate the management of a benevolent or correctional institution of the state. The board or committee has power to send for persons or papers, etc. The report of the investigation is made to the Governor and by him submitted to the general assembly with appropriate suggestions.

The terms of this section have been by an opinion of the Attorney General limited to institutions owned and controlled by the state. There, therefore, seems to be no authority to extend this investigating power of the board to charitable and correctional institutions belonging to municipalities or counties.

The State Board of Administration has power to make investigations upon its own initiative. No outside parties can compel an investigation except through successful application to the Governor.

Pennsylvania.

The act of 1869, which created the Board of Public Charities of the Commonwealth of Pennsylvania, gave it the authority to investigate any public, charitable or correctional institution.

There is no state law prescribing the rules or methods of procedure for conducting such investigation. This is a matter entirely in the hands of the board itself.

Such investigations are made either at the request of the Governor, legislature, or upon the sworn statement of any individual in the commonwealth.

The board makes its report to the legislature and the Governor, or, if the case warrants it, reports its findings to the courts for legal action if necessary.

Tennessee.

The Governor, in his discretion, may at any time order an investigation by the Board of Trustees or by a committee of its members of any penal, reformatory or charitable institution of the state, and said board or committee, in making such investigation, shall have power to send for persons and papers, and to administer oaths and affirmations, and the report of such investigation, with the

testimony, shall be made to the Governor and shall be sumbitted by him, with its suggestions, to the general assembly.

Virginia.

The Governor may order the State Board of Charities and Corrections or any committee thereof to investigate the management of any state institution or any institution receiving aid from the state. There is no law or other authority prescribing the rules or methods of procedure for conducting such investigation, except in the law creating the state board. The State Board of Charities has power to administer oaths, to summon officers and employees to attend as witnesses and to force their attendance, and to compel them to produce documents and to give evidence. Such investigation cannot be compelled by extraneous authorities or outside parties. The party making investigation reports its findings and conclusions to the Governor. Of course the general assembly has a right at any time to order an investigation of any public institution or any institution receiving aid from the state.

Washington.

The Governor or Board of Control can order an investigation of any of the institutions under the supervision of the State Board of Control.

There is no law or other authority prescribing rules of procedure other than as provided in the Board of Control law.

Investigations cannot be compelled by outside persons or authority, but if the proper showing is made to the Governor or to the Board of Control, investigations are made.

Reports of findings in investigations are made to the Governor.

Wisconsin.

Section 565 of the Wisconsin statutes provides the facilities for investigations of charitable and correctional institutions. The Board of Control under that law has power to make an investigation of any institution in which persons are confined by commitment. The board has not adopted any rules governing investigations, but many investigations have been made under the authority given in that statute. The board has investigated poorhouses,

county asylums and state institutions. The report is simply made and filed in the office of the board. Sometimes the Governor requests the board to make an investigation of a given institution and when that is done the report is made to the Governor with a transcript of the testimony taken.

Under the provisions of section 565 the board has power to compel the attendance of witnesses at investigations and to expend such moneys for expert testimony as the board deems proper.

Dominion of Canada.

PROVINCE OF ONTARIO.

The Provincial Secretary has charge of all public institutions such as prisons, gaols, insane asylums, etc. There is an Inspector of Asylums and Prisons who occupies much the same position as the different commissions that exist in many of the United States. The Inspector is a permanent official and gives his undivided time to the work. The Inspector occupies a position between the minister, the deputy minister on one hand and institutional detail on the other.

An investigation can be ordered by the minister, the deputy minister, or the inspector.

IV.

DEVELOPMENT OF HOSPITAL ARCHITECTURE.

The architectural evolution which characterized hospital construction during the building era in the early part of the nineteenth century deserves consideration.

Prior to the year 1840 there was little that was distinctive in any of the buildings, though at one or two, as the Friends' Asylum at Frankford and the Hartford Retreat, an attempt was made to reproduce the plans of the York Retreat in England, which had powerfully influenced the philanthropic movement to better the condition of the insane.

The Hartford Retreat and the Friends' Asylum, in turn, unquestionably influenced the construction of many early private or semi-public institutions in New England, as, for example, the Asylum at Brattleboro, Vt.; the New Hampshire State Hospital; the State Hospital at Worcester, Mass., and the State Hospital at Augusta, Me. In these buildings an effort was made to get the largest amount of accommodation for patients at the least possible cost. The condition of the New England states was still that of communities which had not emerged from pioneer hardships—Vermont, New Hampshire and Maine being all inhabited by a hardy, thrifty, but comparatively poor class of citizens. The soil was not productive; much of the surface of the country was covered with forests and the cultivation of the land was but imperfectly developed.

The influence of England was shown in building the McLean Hospital, the Butler Hospital, the State Hospital at Columbia, S. C., and, possibly, the New York State Hospital at Utica. The McLean Hospital and the Columbia State Hospital are sufficiently alike to suggest a common origin, which may have been from England, or was possibly an evolution of the Old Province House, which formed the nucleus of the former institution. It is interesting to note that the original plans of the hospital at Columbia, S. C., were found a few years ago at the McLean Hospital. They were prepared by Robert Mills, a noted architect of his time, who lived in Washington and practised his profession in Washington,

Baltimore, Charleston and other Atlantic seaboard cities. The plans for the South Carolina institution may have been Robert Mills' modifications of the original plan of the McLean Hospital. The plan of the institution at Staunton, Va., gives many suggestions of French origin and influence. I know of no institution which originally had a pleasanter outlook or better facilities for the segregation of patients of different classes than the Western State Hospital at Staunton, Va. Unfortunately, owing to the necessity of securing accommodation for the insane at the least possible outlay of money, during the period of poverty which followed the civil war, large barrack-like additions were constructed, in connection with the original buildings, which revolutionized the plan and marred its effect very badly.

There was, however, no uniform plan of hospital construction until Dr. Thomas S. Kirkbride, of Philadelphia, evolved the plan of the Pennsylvania Hospital. The first building in West Philadelphia, now known as the Department for Females, was built after a plan brought from England, which had many defects. An unnecessary half-story, rendered possible by excavating the soil and building an area, had been added as a basement. This was unquestionably intended to increase the architectural effect of the building, but the device was unfortunate. After studying the defects of the original building Dr. Kirkbride devised a plan which served as a prototype of institutions throughout the country. It consisted, in effect, of an administration building, of somewhat more commanding and imposing architecture than the wings, which was to be used for offices, store-rooms, and kitchen as well as for a residence for the superintendent and medical officers. On either side of the administration building were wings, extending usually about 150 feet, each wing to be occupied by one of the sexes. These wings terminated in cross sections which gave accommodation to water-closets, clothing rooms, and bath-rooms, while at right angles from the cross sections were other wings which could be extended indefinitely. In some instances four sets of longitudinal wings and cross sections were arranged for the care of different classes of patients. The theory was that convalescents and quiet patients would occupy the wards close to the administration building. Patients in an intermediate state would occupy the wards nearest the convalescent ward, and patients who

suffered from severe excitement or were especially objectionable by reason of noisy outcries or turbulent conduct were placed as far away from other patients and from the administration building as possible. Each ward was complete in itself, that is, each possessed a bath-room, water-closets, clothes-room, dining room, etc. By means of miniature railways with provision cars and dumb waiters for service, it was possible to supply food from a central kitchen adjacent to the administration building.

The plans, as formulated in a series of 26 propositions by Dr. Kirkbride, were formally adopted by the Association of Superintendents of Institutions and, as a result, buildings were constructed on the Kirkbride plan in almost all the states of the Union. I can recall them without effort in New Jersey, Ohio, Michigan, Illinois, Wisconsin, Kentucky, Tennessee, North Carolina, Georgia, Alabama, Louisiana, Mississippi, Texas, Iowa, Minnesota, Nebraska, Kansas, Virginia, Maryland, District of Columbia, West Virginia, Missouri, New York, Massachusetts, Connecticut, Maine, Utah and California. Some or all of the institutions for the insane in each of these states were built according to the Kirkbride linear plan, which had many advantages. The buildings were not expensive and they were easily managed, which was an important matter at a time when the conception of the superintendent was that of an officer who attended to all the details of the institution. He was supposed to have medical charge of every patient; he was generally treasurer; he looked after the purchase of supplies; and he had the responsibility of the management of the kitchen, stables, farm and all other business enterprises connected with the hospital.

The buildings thus erected were usually semi-fireproof. They gave easy access to the grounds and from their arrangement it was practicable to add to them without destroying the architectural symmetry. Unfortunately, however, the addition of successive wings sometimes rendered the farthest building difficult of access. In the Buffalo State Hospital, for example, which is probably the most extreme type of building constructed after this plan, the medical officers must walk a distance of half a mile from the administration building to reach the farthest ward on either side. The buildings were usually heated by steam, but if they were in exposed situations they were difficult to heat. It should be added that the buildings at Utica and at the Pennsylvania Hospital

were originally heated by hot air furnaces, which proved to be inadequate, so that early in their history a change was made to heating by steam, distributed in coils in the basement, ventilation being effected by currents of air entering through air-chambers, also in the basement, passing over the same steam coils, and reaching the wards as warm fresh air, a system which is now known as indirect radiation. In most institutions a ventilating fan was provided to force a positive circulation of air through underground ducts over coils of iron pipe heated by steam and into the wards through inlet flues. Outlet flues from the wards usually terminated in the attic and foul air was supposed to find its way out through louvres in cupolas. Unfortunately, although forced ventilation was provided in many institutions, the system was not always effective and institutions, as a whole, suffered from too much heat and too little fresh air.

For many years the " propositions," modified from time to time as exigencies demanded, formed a set of cast iron rules, which governed the construction of hospitals. At first the scheme contemplated institutions of not more than 200 patients. Later on, through force of circumstances, it became necessary to sanction the erection of separate departments for each sex, as at the Pennsylvania Hospital in Philadelphia, the Indiana State Hospital and the Michigan Hospital at Kalamazoo. These departments were not individually to accommodate more than 250 or 300 patients each, but the whole institution thus enlarged became unwieldy and difficult to manage. Many accomplished superintendents felt that if they must have the care of 600 patients it was better from an administrative standpoint to have the buildings near at hand and easily controlled, rather than to attempt to manage two distinct establishments with a divided authority. Many older superintendents resented any effort to break away from the original plan. As we now view the question, it is apparent that while the Kirkbride " propositions " were valuable in an early stage of the movement to care for the insane, and were an excellent example of economical and easily administered buildings, they made the mistake of emphasizing too strongly the custodial features of institutions and were not sufficiently flexible to meet the requirements of all classes of patients. This became so apparent that in many older institutions, presided over by men thoroughly in sympathy with

the original "propositions," cottages were added to accommodate the chronic insane, farm laborers, and harmless persons requiring custodial care rather than institutional treatment. At first the intention was to make these cottages like private houses, to accommodate 20 or 30 patients. Soon, however, the necessity of relieving institutions of the constantly increasing burden of chronic patients led many men to advise the construction of cottages containing 50, 100, 200 and even 300 patients. These buildings, as a rule, were simple in construction and accommodated patients almost wholly in dormitories. Partly to secure more room and partly to insure a greater economy in feeding patients, there grew up kitchens, dining and service rooms, at a central point to which patients from all parts of the institution were sent to take their meals. This arrangement allowed the food to be distributed with less expense, and in a more appetizing condition as regards both cooking and service. It also enabled many institutions to convert the individual dining rooms in every ward into dormitories and thus to accommodate a larger number of patients.

The first notable departure from the original "propositions" was at Willard, N. Y., where the necessity of accommodating 2000 patients of the chronic class at a comparatively low cost *per capita* rendered it essential to plan a series of block buildings about a central hospital and administration building. Dr. Chapin, the able planner of Willard, who was also the first superintendent, always declared that he acquiesced reluctantly in the plan of an administration building with adjacent wards on the Kirkbride plan and only gave his consent because general sentiment was overwhelmingly in favor of such provision. All experts who were consulted had grave doubts as to the wisdom of providing for patients in any other manner and were not favorably impressed with the utility of detached buildings, which afterwards became a feature at Willard. It was unfortunately a part of the original plan to utilize a large building upon the estate, which had formerly been occupied as an agricultural college. In converting this building into wards for patients many mistakes which had been made in earlier institutions were inevitably repeated. Eventually the danger of fire in a high building, not fireproof and crowded with helpless patients, compelled the erection of infirmary buildings for the care of such

feeble and helpless people. The old agricultural college was then reduced from four to two stories and practically rebuilt.

The first institution to be constructed on what is known as the cottage plan was the Kankakee State Hospital, which owed its inception to the versatility of the late Fred. H. Wines, then secretary of the Illinois Board of State Charities. Mr. Wines had felt for a long time that the custom of erecting uniform buildings for different classes of the insane failed to meet the requirements of patients and conceived the plan of reproducing on an ample tract of land the conditions of a country village. The initiative was undoubtedly his, but the credit of the details of the institution was largely due to Dr. Dewey, who entered into his plans with great enthusiasm. Unfortunately, the mistake was made of constructing an administration building on a large scale with wards adjoining. This procedure, as at Willard, increased the initial cost of the enterprise unduly and unquestionably interfered to some extent with the development of the scheme as it originally appeared to the mind of Mr. Wines. The village idea has always been attractive to many who are interested in provision for the insane, but in some instances the village conception has increased the difficulties of administration and added largely to the cost of construction, because, instead of a village, the ambitious architects have undertaken to make a town. Probably the most prominent example of this is shown in the Craig Colony at Sonyea, N. Y. Here no expensive wards or monumental administration buildings are required and the condition of patients is such as to permit free open air life with a minimum of control. The result has been the erection of a very large number of buildings on each bank of a deep ravine which separates the two sexes. The institution, in fact, consists of two villages with 70 or 80 different buildings. The effect upon the visitor is not wholly pleasant. The buildings are expensive to keep in order, because of the large extent of roof space where no building is above two stories in height, while if such buildings are not kept in perfect repair, or if they become discolored by smoke and stained by weather, they do not present an attractive appearance.

The institution at Kankakee was constructed in streets and with groups of somewhat expensive stone cottages. Some of the buildings had an independent heating installation, but the majority

were heated from a central point. In view of the claims made by those who advocated the cottage plan that in case of fire patients would be much less liable to danger and could be gotten into the open air with little difficulty, it is interesting to remember that a destructive fire in one of these cottages with considerable loss of life occurred early in the history of the institution.

It has always been a matter of regret that before the final elaboration of the Kankakee State Hospital a reorganization of all the institutions of Illinois, in the interest of a political party which had recently come into power, drove out of the service all persons who had been interested in its true development, including Mr. Wines and Dr. Dewey. The development of the institutions as a consistent cottage system ceased; whatever has been done since has been accomplished in a haphazard manner with a view to sheltering patients, rather than to providing appropriate buildings.

The next institution upon the cottage plan to command wide attention was built at Toledo, Ohio, largely as the result of the efforts of General Brinckerhoff, a member of the Board of Charities, and the Rev. Dr. Byers, its secretary, who induced a commission from Ohio to visit Kankakee, in order to confer with Mr. Wines in reference to the village plan. The committee recommended the adoption of the cottage plan in all particulars, with small detached buildings for the accommodation of different classes of patients and two large congregate dining rooms, one for each sex. As might be expected in building such an institution certain mistakes were made, which, with more experience, might have been avoided.

The site chosen was not favorable and the buildings themselves were not attractive, but in spite of these defects, when the completed institution was opened to the public, it was evident that a new departure had been made in building for the insane. Those familiar with the later history of the Toledo State Hospital will notice that in the buildings subsequently erected a tendency developed to increase the size of the cottages and to rebuild them more expensively than was originally intended. Formerly all patients occupied day rooms on the lower floor and had dormitory accommodations on the upper floor. In the changes and additions which have been made during recent years both floors of many of the cottages have been converted into dormitories. This is in some

respects a retrogression from the original plan, due no doubt to the fact that the institution had become crowded and it was necessary to secure additional room at the smallest expense.

The next important departure in hospital architecture was in a new institution at Ogdensburg, N. Y. This institution had the advantage of the previous experience of Dr. Peter M. Wise, of Willard, who had served on the commission to locate the Ogdensburg Hospital and to prepare plans for it; consequently certain defects which had been practically experienced at Willard were remedied.

The desirability of providing for certain classes of the insane in separate buildings was recognized and the cottage plan adhered to, but these buildings were so grouped as to promote the comfort and convenience of all parts of the institution. There was an inexpensive administration building and adjacent to it were buildings for cases of acute disease; farther removed were those designed for convalescent cases and mild mental disorders; beyond were those designed to accommodate cases suffering from excitement; and, in a separate group, provision was made for chronic cases engaged in out-of-door work.

The excellence of this institution has been universally attested by all persons who have visited it. It is doubtful, however, whether an institution of this type can be economically conducted in the cold winter climate of Northern New York, where for several months it is difficult for patients to take exercise in the open air or to go to and from central dining rooms to get their meals. So great an amount of isolation of patients scattered in different groups of buildings has necessitated a disproportionate outlay for fuel to keep them comfortable and has raised the inquiry whether the benefit gained by segregation is worth the increased cost necessitated by it.

Somewhat later a similar experiment was attempted under more favorable conditions at the Springfield State Hospital, near Sykesville, Md. Here, upon a fine farm of upwards of 700 acres, with pleasant and convenient building sites, separated from each other by water courses and ravines, have been located groups of patients in separate and distinct buildings. There is a group for women patients, which constitutes a complete institution in itself, with dining rooms, serving rooms and kitchen, as well as a group for

male patients, similarly arranged. Buildings for chronic cases, for working patients, and for epileptics are situated at convenient distances from each other, each group being under separate medical control, but also under the general care of the superintendent, whose residence is convenient to all the groups. This arrangement has proven unusually well suited to the segregation of patients and, because of the comparatively mild winter climate of Maryland, the expense has not been onerous.

In Michigan, at the Kalamazoo State Hospital, an interesting modification of hospital life was secured by the establishment of so-called farm colonies for the chronic insane. The first attempt was a colony for male patients who were farm laborers, which was situated about three miles from the hospital and was administered practically as a separate institution under the charge of lay-managers, although visited daily by a medical officer.

Here were gathered all the cattle of the institution and from this farm milk was sent in wagons to the main hospital. Here were pig pens and poultry yards, the occupants of which were fed by the garbage of the institution transported daily in covered carts to the colony. The cultivation of small grains, vegetables, garden berries and fruits was encouraged. The men who resided at the colony were comfortable, contented and happy and their labor became an important factor in the economical development of the colony. Unfortunately the high cost of land in the vicinity did not permit the extension of the colony in this location. Subsequently, to provide for the overflow of chronic patients, a second tract of land was procured about two miles south of the main hospital, which has since been extensively developed and has contributed much to the comfort and welfare of both male and female patients.

In Alabama provision was made for the colored insane at an abandoned military post, known as Mt. Vernon Barracks, 40 or 50 miles from the parent institution. The barracks had been erected by the general government and when no longer needed were ceded to the state and utilized for the care of the colored insane of Alabama. The colored patients at Mt. Vernon, both men and women, are employed in various forms of out-door labor and their labor is a distinct advantage to the institution.

It will be noticed that in these architectural changes in institutions there has been a steady development away from the linear

form of hospital construction. In most of the colony cottages, arrangements are made for dormitories on the second floor and for day rooms, sitting rooms and service rooms upon the first floor. Many of the buildings are complete, with kitchen, dining rooms and work rooms, and the work of the house is done by patients.

At Central Islip, N. Y., there is a similar development of isolated buildings for the accommodation of chronic patients who are able to employ themselves in useful labor. The organization seems to be semi-military, the patients going to labor at definite hours, and returning at the stroke of the bell. They march to a central dining room at a definite time and return to labor at a fixed hour. Through the labor of patients an uninteresting and unproductive tract of ground has been made to blossom and to produce large returns. The institution has developed out-door industries, probably to a greater extent than any other, and while the buildings are not upon the group plan, they are so arranged as to make an effective separation of patients.

In Kansas the colony system of caring for the insane has been incorporated into the general law and the same thing is true in Colorado. The most elaborate of the newly erected institutions on the cottage plan are probably to be found in Indiana, where two institutions, the Eastern and the Southeastern, have been built in this manner.

It is evident that for many years to come provision for the insane in the United States will take this form rather than that originally laid down in the "propositions."

CHAPTER VI

DEVELOPMENT AND EXTENSION OF METHODS OF TREATMENT

I.

THE PROPOSITIONS.

A brief consideration of the "propositions" seems essential to a proper understanding of the manner in which the older superintendents viewed their work and responsibilities. It must be remembered that the majority of the superintendents, if not all, who assumed charge of institutions for the insane at first were engaged in a new and untried work. They had strong convictions as to what should be done and were fearful that mistakes might be made by those who sought to establish institutions in newly developing pioneer communities. Although they had as a rule the support of an enlightened public sentiment, more especially of the medical profession, they realized that they owed a duty to the public to lay down certain fixed principles for future guidance. The object of the "propositions" undoubtedly has been misunderstood by many critics, because it has been interpreted in the light of our present knowledge. We know now, after years of experience, that the views of the older men were too hard and fast, and their "propositions" as originally expressed lacked sufficient elasticity to adapt themselves to changing conditions, created largely by the error of earlier views as to the curability of insanity. It is unquestionable, however, that the "propositions" were necessary at the time they were written to secure the proper construction and organization of such an institution as was contemplated by the earlier men who engaged in the treatment of insanity. The success of the hospital then depended largely upon the personal labors of the superintendent who was, as I have indicated in another place, not only superintendent, steward and medical expert, but also sole physician. Under such an organization it is not strange that it was thought essential to keep the number of patients small, so that each one might have the personal care and supervision of the superintendent.

The first "proposition" enunciated at the first meeting of the Association in 1844 related to personal restraint of the insane. The last "proposition," giving expression to the views of the Association as to proper provision for inebriates, was adopted in 1875.

During the intervening 30 years many declarations of opinion were placed in the minutes of the Association, all of which were useful and the majority of them most timely and necessary.

In following the history of the Association careful consideration must be given to the import of the "propositions." They were the deliberate utterances of the leading minds of a body of men personally engaged in the care of the insane, and in every instance they represented conclusions which had been reached after much thought and no little experience. The declarations were not in any sense *doctrinaire* theories evolved in the study, but were the results of experience and reasoned conviction. The persons who originally engaged in the treatment of insanity in the United States, although not experts in the work, were none the less capable physicians and philanthropic and sagacious men who felt it to be their duty, while they were exploring a hitherto unknown region, to leave behind them a blazed trail to guide those who should come after. They had no thought that they had acquired all knowledge attainable upon the subject and had reached ultimate conclusions, but they were impressed with the fact that they had found some methods preferable to others and these methods they gave to the world.

The declaration in 1844 at the first meeting of the Association that "it is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane," undoubtedly represented the settled convictions of the greater part of those who were caring for the insane at that date. There lingered in the minds of all a trace of the old traditions that the insane had a degree of perversity which required corrective measures. Rush still dominated the medical world and his views as to the necessity of breaking the wills of patients were familiar to all and were generally accepted. It is probable also that the sternness which characterized New England family life had something to do with the feeling that restraint and correction were essential to proper care and cure. The moderation of the declaration is more surprising than the mere sentiment; it indicates the existence of a conviction that personal restraint is not a blessing and seems in marked contrast to the sentiments enunciated by members of the Association a quarter century later.

The "propositions" which were formulated for the construction of hospitals for the insane were perhaps the most important and far-reaching in their influence. They provided in brief that every hospital should be in the country not less than two miles from a large town and easily accessible at all times, upon a site containing not less than 50 acres of land devoted to gardens and pleasure grounds, and, if a state hospital of 200 patients, comprising not less than 200 acres; that at least 10,000 gallons of water should be supplied daily to reservoirs commanding the highest portions of the buildings; that no hospital should be built without the submission of the plans for approval to a physician or physicians who have had practical experience in a similar establishment; that not more than 250, and preferably 200, patients should be placed in one building; that the buildings should be constructed of stone or brick, with slate or metallic roofs, with ample and accessible stairways of iron, stone or other indestructible material to afford egress in case of fire; that every hospital should have at least eight distinct wards for each sex, each ward with a parlor, corridor, single bed-rooms, associate dormitory, clothes-room, bath-room, water closet, dining room, dumb waiter and speaking tube communicating with the kitchen; that all rooms for patients should be above ground not less than eight by ten feet, with ceiling at least 12 feet in height, with outside windows, and floors of wood; that there should be a central building for offices, living rooms for officers and others and separate wings for each sex; that the lighting should be by gas; that the laundry should be in a detached building; that there should be sewers, steam or hot water heating and forced ventilation; that all boilers for steam power should be in detached buildings; that water closets should be of indestructible materials and ventilated and their floors of non-absorbent material; that the rooms of wards for the most excited also should be on one side of the corridor at least ten feet in width with external windows affording pleasant views, and, finally, that the pleasure grounds should be surrounded by a wall.

The "propositions" in regard to buildings were not the final word in the matter, as all will concede, but they initiated an era of better buildings and prepared the way for more hygienic surroundings for the insane. The economy practised in such plain, substantial structures unquestionably had a favorable influence upon the building of similar institutions in pioneer states.

The limitation of the capacity of proposed hospitals to 250 beds for patients, as adopted "unanimously" in 1851, was extended, by a vote of nine to five, to a permissible accommodation of 600 in 1866.

Respecting the "legal relations" of the insane, Dr. Ray's elaborate "project of a law" is memorable only because of one or two features. The first providing for the appointment, by judges, of juries composed entirely of physicans, one of whom, for each jury, if practicable, shall be an expert in insanity, to settle the question of the mental competency for trial of persons accused of crime, but pleading insanity as an excuse; and the second, making it obligatory on the part of the prosecution to prove that the criminal acts of an insane person on trial for crime were not the result of insanity, direct or indirect, in order to establish any degree of responsibility for such acts.

The Association disapproved of the admission of insane criminals or of inebriates to hospitals occupied by other classes of insane persons; but urgently recommended public provision for them both as separate classes.

In 1853 a similar elaborate series of "propositions" in relation to the organization of hospitals for the insane was prepared by Dr. Kirkbride. They were also most useful and timely and have accomplished much good. Their usefulness in fact has not yet ceased. Those who read them can readily understand how greatly these clear-cut and well-considered phrases influenced persons who were about to organize new institutions.

In 1866 elaborate and carefully framed resolutions were adopted in regard to the care of the several classes of insane. These principles still govern public policy in the majority of the United States to-day, which fact attests the validity of the sentiment therein expressed.

In 1871 a series of "propositions" involving a project of a law to control the legal relations of the insane was adopted.

The "propositions" in reference to the construction and organization of hospitals was undoubtedly the work of Dr. Kirkbride; the "propositions" as to the legal relations of the insane and the project of a law were framed by Dr. Isaac Ray.

It had been evident, however, for many years prior to 1875 that the needs of the country had outgrown the special form of hospital

accommodations which had been deemed ample in its earlier history. It was also equally apparent that the older men who fathered the original scheme had grown to regard it as the only proper method of caring for the insane. Such mistakes are often made by elderly men who seek in vain to arrange the world and to set it in order for all future time.

Animated debates over the "propositions" occurred in successive meetings of the Association and more or less personal feeling was generated between the younger and older members. The latter worshipped the "propositions" with a deep and fervent veneration and seemed to regard them as sacred, while the former believed them to be outgrown and no longer necessary. The weight of argument was clearly with the younger members, because, notwithstanding the prohibition of institutions beyond 250 patients, many institutions were already accommodating 1000 or 1200 persons. The author of the "propositions" even had been compelled to extend the Pennsylvania Hospital far beyond the original number by the construction of an entirely new department under his own control, but nominally supervised by an assistant physician. The need of care for insane patients, however, had become so great in rapidly growing states it was impossible to limit the numbers of any institution or even to predict the extent to which they might eventually be increased.

In the year 1888, at a meeting of the Association at Old Point Comfort, an elaborate report signed by Dr. Orpheus Everts and Dr. Foster Pratt was presented, which gave rise to an animated debate, characterized by considerable plainness of speech on the part of the friends and opponents of the "propositions." The committee recommended that economy, humanity and the wisdom of experience suggested the propriety of the separation of classes of patients and different provision for them, such as hospitals for acute and active insanity, asylums and homes for the class permanently impaired by disease and training schools for the education and training of those naturally defective. The committee recommended a departure from the former method of constructing all institutions upon one plan and suggested that they should be divided into small wards especially adapted to the needs of acute forms of disease. They should be fireproof, tasteful and attractive in appearance. The asylum proper or home for incurable patients

should be furnished more with reference to daily use and constructed comfortably, spaciously and economically, with a view to utilize the energies of chronic patients in useful employment.

Buildings for the custody and treatment of insane criminals should embrace hospital, asylum and prison features combined.

In the matter of organization of the hospital and asylum the report did not deviate materially from the original "propositions," but entered more into detail as to the character of boards of trustees and the qualifications of superintendents of institutions and their tenure of office.

For the care and treatment of the insane there could be no inelastic system or prescribed rules. The committee was strongly in favor of individualized treatment and the special study of insanity to ascertain its cause and the best methods of prevention.

In the matter of the legal relations of the insane the report of the committee was extremely sensible. It proceeded upon the assumption that all insane persons should be considered wards of the courts and that the legal status of insane criminals under the law should be that of minors who are not fully responsible for their actions. The committee did not believe in the doctrine that the presence of any and each degree of mental impairment might be an unconditional excuse for any crime, but thought that in all legal proceedings, when insanity is pleaded as an excuse for crime, the degree of mental impairment should be considered.

Such in substance were the changes in the "propositions" contemplated by the committee. The report in the light of present views does not seem contrary to the general principles already established. It met, however, active opposition and was debated with much warmth of feeling. Finally, it was decided by a small majority that in the judgment of the Association there was no necessity of reaffirming the original "propositions." A second resolution was added that it was inexpedient to adopt any new "propositions." These two resolutions seem to indicate that the life of the "propositions" had departed. A resolution was subsequently adopted asking the chairman of the committee to present his views personally at the next meeting of the Association, but nothing came of it and during the past 25 years no effort has been made to reopen the question, either by repealing or reaffirming any of the existing "propositions."

II.

REFORMS IN CARING FOR THE INSANE.

It is interesting to note that while the humanitarian sentiment of the whole country favored the treatment of the insane in well-organized institutions, constructed according to advanced ideas, as to individual air-space, pleasantness of situation, abundance of ventilation and efficient heating, so that in fact the early buildings for the insane were in most instances far superior in site, ventilation and heating to schoolhouses, churches, colleges and even general hospitals, yet no great pains were taken to study questions which affected the personal comfort of the patients placed in such exceptionally well-arranged and well-designed institutions. This was due largely to the fact that philanthropists and others interested in the proper housing of the insane failed to appreciate a most important truth in reference to insanity: that the violent, destructive and often dangerous tendencies of the insane were a part of their disease and not a manifestation of perversity requiring forms of restraint often deteriorating into punishment.

Up to the year 1880 patients were subjected to direct and indirect mechanical restraint. They were placed in cells, the fixtures of which were generally so arranged as to render it comparatively easy to neglect those who occupied them, and were often deprived of the ordinary comforts of life. If the insane destroyed clothing, they were left without it; if they broke up furniture it was taken away; if they declined to lie upon beds, the floor was supposed to provide ample accommodations for them. The same *laisses-faire* theory characterized the provision made to give patients exercise in the open air. They were placed in airing courts surrounded by high walls, which were more like places of confinement than grounds designed to promote comfort, diversion or active exercise. These airing courts were doubtless better than the ordinary cell, but, except for the fact that they were in the open, they suffered under much the same limitations as the smaller, darker and less ventilated cells of the institution. There was little in their arrangement and outlook which suggested any change of scene to the patient oppressed by morbid thoughts, nor were they calculated to

promote his self-respect or self-control. This, however, was not the worst of the difficulties which were encountered in the care of the insane. In many instances insane patients were destructive to clothing and to furniture or were violent and insulting in their relations to those who had them in charge as nurses or attendants. It is interesting to observe how the older writers among the superintendents of institutions theorized as to the remedies for this state of affairs. They argue that, as insane persons were irresponsible and incapable of self-control, it was necessary that they should be restrained by mechanical means until such time as reason and self-control reasserted themselves. Hence it became customary to use mechanical restraint in almost every case characterized by excitement. In the literature of insanity it began to be stated as an axiom that, as insane patients were unable to control themselves, it was the duty of the medical officer to see that they were controlled. In other instances mechanical restraint was employed to prevent suicidal as well as homicidal attempts. It was not uncommon for a suicidal patient to be placed in mechanical restraint by day and by night.

Motives of economy also seemed to encourage the use of mechanical restraint because of the expense incident to the destructive tendencies of patients. A certain amount of mechanical restraint was thought necessary to save the institution a large outlay for bedding, clothing, furniture and the like which would otherwise be needed to replace articles destroyed by excited patients. It was honestly believed that mechanical restraint was less irritating and annoying than personal control at the hands of stalwart attendants, because easily understood by insane patients to be necessitated by their destructive tendencies. This may have been true to a certain extent, but the whole theory of restraint was based upon a fallacy which later on, when attempts were made to do away with it, became self-evident. The fact that a patient made a homicidal attack, or was destructive, or dangerous, or suicidal, did not necessarily imply that, unless he was continuously restrained, he would be continuously suicidal, destructive or homicidal. That these acts were not due to irresistible impulses, but were passing phases of a long-continuing disease, was often overlooked by those who had the care of such patients. During the era of restraint it was customary to see patients restrained, secluded or

in solitary confinement for weeks, months, and even years. The explanation of such treatment often given by physicians and nurses was that the patient required restraint because of some previous act of violence, but in some instances these acts were so far in the past as to become matters of tradition. Although he might have committed no violent acts during the period of restraint, it was, nevertheless, firmly believed that he would have committed them had be been at liberty, and hence he was regarded as still dangerous to himself or others and still in need of continuous restraint.

When mechanical restraint was finally removed in consequence of the growing reform of methods it became apparent that its application in the majority of cases had developed and rendered continuously active the very tendencies which it had originally been designed to remove. Patients because of restraint had become violent, morose, moody, revengeful, destructive to clothing, untidy and in many respects most disagreeable. As a matter of fact, when non-restraint was generally adopted in the United States it was found that many institutions were filled with a dangerous, destructive, degraded and violent class of chronic cases which was not found abroad and which no longer existed, indeed, in institutions where methods of non-restraint had been practised for a few years. Restraint had tended to perpetuate acts of violence and destructive habits and had so aggravated them as to create a distinct class of violent patients in every hospital. The remedy had plainly been worse than the disease. Under the restraint system many patients had passed their lives in restraint and seclusion with little or no effort to provide them with employment, out-of-door exercise, proper amusement, or to introduce into their lives any influence calculated to divert them from morbid fancies or supply an active, healthy outlet for normal energies.

The question of the comparative wisdom of restraint and non-restraint was frequently brought to the attention of members of the Association by the criticisms made by visitors from abroad, who were familiar with non-restraint methods in English institutions. From 1850 to 1880 scarcely a session of the older Association of Superintendents of Institutions for the Insane was held that the matter was not debated. It is evident that the attitude assumed by the majority of superintendents was in favor of restraint, although an occasional voice was lifted against it.

One of the earliest advocates of the non-restraint method of caring for patients was Dr. Richard Gundry, of Ohio, who had inaugurated the system in the Athens State Hospital, of which he was superintendent at that time. The most earnest advocate of restraint was probably Dr. John P. Gray, a forceful and influential man, then superintendent of the Utica State Hospital. He believed that restraint was essential not only to the comfort and recovery of patients incapable of self-control, but in the case of those suffering from acute and debilitating forms of mental derangement, who were exhausting themselves by unrestrained movements and extravagant actions, and he regarded it the duty of every superintendent to prevent this tendency to exhaustion, as far as possible, by keeping all violent or excited patients forcibly in bed. In pursuance of this idea feeble patients in some institutions were prevented from getting out of bed at night, or exposing themselves during severe weather by day, by placing them in covered beds where they could not assume even a sitting posture. At one time the so-called " Utica crib " was highly praised and regarded as of great service. It is now remembered that, no matter how many beds of this kind had been provided for a given institution, all of them were in use and all seemed necessary. The presence of the covered bed led to its use. Later on, owing to the spread of non-restraint methods and just criticisms upon this form of restraint, it was found that patients did not exhaust themselves by sleeping in open beds, nor were they more liable to injury or disease than when under conditions of restraint.

About the year 1880, largely as a result of observations made by superintendents who had visited institutions in England and Scotland or upon the Continent, there developed a strong feeling that in the matter of restraint the institutions of the United States and Canada had fallen behind the methods employed in the older countries.

Visitors to European countries who inspected institutions saw comparatively few cases with violent or destructive propensities. Various somewhat amusing explanations were given of the greater quietness of patients in England and Scotland as compared with America. The most common one was that the American, being an independent citizen, a sovereign in his own country, with a belief that no one had any right to place him in confinement or to abridge

his freedom of action, very naturally resented all control. Another popular theory was that the greater violence and destructiveness of patients in America was due to the presence of large numbers of insane foreigners, who had not been accustomed to liberty and who regarded it as license rather than enlightened freedom. I remember one instance cited in confirmation of this theory, that of an Irish patient in an English institution, who, when he first came under treatment directly from Ireland, was quiet, well-behaved and amenable to treatment. Later, however, when he returned to the English institution after a residence in America, he was found to be a violent, dangerous and altogether undesirable patient. Such was the reputed effect of free institutions. The more stimulating quality of the climate of the United States was also assigned as the cause of more frequent acts of frenzied violence.

Both in Canada and the United States sporadic attempts had been made at an earlier date to dispense with restraint, oftentimes, unfortunately, without adequately educating the officers and attendants of institutions in the principles underlying the new régime. The effect of these ill-considered efforts had been to discourage those who had the immediate care of patients and to convert hitherto quiet, comfortable wards into scenes of great disorder and confusion. These unfortunate results were due largely to the fact that those who attempted the reform failed to appreciate that a simple removal of restraint was not enough and that the patient thus released must have some active outlet for his energies. Hence it was essential that occupations suited to his mental condition, especially those carried on in the open air, should be provided, in order to change his mental attitude and to furnish a substitute for the control from which he had been released.

Wherever non-restraint was adopted carefully and judiciously it promoted the comfort and well-being of the patient. But where non-restraint was simply decreed, without any plan to furnish a substitute for it, it was found that the relations between patient and nurse became extremely unpleasant. The nurse forbidden to use mechanical restraint sometimes resorted to force and intimidation, which terminated in personal collisions between the patient and his nurses. Not a few of the earlier attempts at non-restraint failed because of this failure to devise occupation for the patients.

During the past quarter of a century non-restraint has made its way generally throughout the United States. In some states, as in Massachusetts, it has become a matter of state policy, mechanical restraint, unless under exceptional conditions, being forbidden by law. The effort has been to substitute nursing and kind personal care for mechanical restraint and intimidation. The nurses, not being allowed to penalize the patient by confining his hands, or feet, or person, must contrive to get along with him. In order to effect this they first make friends with him and show themselves to be nurses and not keepers. It soon became evident to all who had personal care of the insane that nurses should be helped to devise methods of employment for the energies of patients who were no longer in restraint and seclusion; hence among female patients there followed a great development of household industries. Patients were encouraged to assist in the laundry, in the sewing room and mending room, as well as to engage in fancy work, braiding rugs, rug-making, carpet weaving and a thousand and one feminine occupations. Among the male patients it was found desirable, in the majority of cases, to devise out-of-door occupations in the form of wheel-barrow work, the care of cattle, the cultivation of the ground, cutting wood, hauling coal, etc. Those who were unable to engage in employment of this kind or were not accustomed to out-door work found excellent occupation in shoe-making, brush-making and similar minor industries. The effect of this change has been to improve the condition of the insane in the United States to a remarkable degree. Violent, destructive and outrageous patients are now the exception, where formerly they were the rule.

Careful inspection of institutions in the United States and Canada, as compared with those abroad, shows that insane patients in America do not differ very materially from those found abroad. The change of type and the exaggeration of unpleasant characteristics, so learnedly commented upon by early writers and visitors, are now generally agreed to have been due to faulty methods of control, which aggravated and did not cure the condition.

The disuse of restraint upon a large scale was first attempted in Canada by Dr. R. M. Bucke. The next important step in doing away with restraint was taken in Michigan, where, in the course of a few months, the system which had been common in all the state

institutions was gradually and quietly relinquished, to the manifest improvement of the condition of the patient.

Similar movements soon followed in New York, Massachusetts, Ohio and many other states, until, at the present writing, there are comparatively few states where mechanical restraint is employed.

In Massachusetts Dr. C. W. Page, for many years superintendent of the Danvers State Hospital, gave much careful attention to the matter and developed a public sentiment which has found expression within the past two years in an act passed by the State Legislature forbidding restraint except under special and unusual conditions.

The abolition of restraint, as previously stated, would have been impracticable and unwise had it not been for the development of industries, the abolition of airing courts and the destruction of restraining apparatus. In one state, under a new superintendent, a dramatic destruction of restraining apparatus took place upon a holiday, when, in the presence of the patients, after a prayer from a clergyman and an oration from a politician, two wagon loads of restraining apparatus were burned. In other institutions, while there was probably less demonstration, the abolition of restraint was equally effective.

III.

MEDICAL TREATMENT OF THE INSANE.

It is interesting to notice in the early history of institutions how much attention was paid to medication; almost every institution had formulæ, each containing many medical ingredients for various forms of insanity. Certain remedies were used in excitement, others in depression, others in dementia, etc. One of the most interesting aspects of the treatment of patients, the original idea being derived from Benjamin Rush, was that maniacal excitement required blood letting. At the time of the opening of the Hartford Retreat, the Worcester State Hospital, and even the Utica State Hospital, nearly 20 years later, it was found that all patients who came to the institutions suffering from maniacal excitement had been subjected to repeated blood letting. It was also evident that while the immediate effect of the operation had been to quiet the patients, the after-effects of it were to destroy every chance of recovery. This was later shown by Dr. Earle in a series of observations, both in this country and Europe, to which reference has already been made.

There are few records of bleeding in connection with hospital care, and the practice seems to have been very generally discontinued in institutions. In place of it, however, sedatives were given, especially in connection with excitement, as well as emetics and sometimes very active cathartics. Reliance was also placed upon calomel or blue pills, Dover's powder with quinine, ipecac, tartrate of antimony or some other very active heart remedy. Digitalis, hyoscyamus, camphor and the preparations of opium were also given.

In a number of the meetings of the Association there was much discussion and a pretty general unanimity of opinion that certain remedies were to be used in excitement, as, for example, etherization to control maniacal excitement, or opium to relieve the unpleasant phenomena of depression. Most of the patients were kept under more or less constant medical treatment which generally took the form of tonic remedies calculated to improve the appetite and the general nutrition.

Dr. Edward Cowles,[1] in a paper printed 20 years ago, says:

These teachings of Rush long controlled the treatment of insanity by general practitioners in America. But these depletory and reducing means were practically discarded by the earlier alienists who came after Rush. The Frankford Asylum, opened in 1817, employed the mild methods of the York Retreat in England, and exercised a most salutary influence by its example. At the McLean Asylum in 1818 Dr. Wyman adopted the system of Pinel and Tuke, and was opposed to depletory treatment; and Dr. Bell in 1841 wrote that "the practice of bleeding, violent purgation, emetics, vesications and derivations has passed away before the light of experience." In the earlier years of the Hartford Retreat, which was built in 1824, Dr. Todd insisted upon generous diet, and recommended a frequent resort to tonics and narcotics in the medical treatment of the insane. He found that it required considerable boldness and address to introduce this plan of treatment, contrary to the teachings of Rush. These rational views were advocated by Brigham, Ray, Bell, Kirkbride, Curwen, and many others. But Earle, as late as 1854, found occasion for a strong protest against the general practice of blood-letting in insanity as an error then generally prevalent.

The practical therapeutics of that time, from 1840 to 1850, may be summed up, truthfully perhaps, as follows, both for England and America: With the discarding of the theories of inflammation and depletion as the prime indications in insanity, the practice of a "supporting treatment" had come into favor, with medication aimed at meeting the symptoms as they appeared. About 1840 it was, with many, the rule of practice to regard it as an important first indication to meet the symptoms of local congestion, especially when there was evident determination of blood to the brain. But in the treatment of this condition only local bleeding was approved in the best hospitals, and that under many cautions against exhaustion or collapse. Emetics were regarded as useful in torpid states, as in melancholia with dyspeptic disorder. The best method was to use tartrate of antimony, which was found most efficient often in mania. But care was to be taken not to be misled by the calmness thus produced, which arises from exhaustion.

Purgatives, laxatives and enemata were used with much of the careful discrimination taught by modern therapeutics, the less drastic remedies being best approved. Preparations of mercury were used with more care than before that time. Opium, narcotics and sedatives were in general use; these included hyoscyamus, belladonna and conium. They were used to allay excitement or agitation or as hypnotics. Opium and morphia, while their use was regarded as requiring discrimination, were believed to be liable to cause phrenitis in cases of cerebral congestion and great vascular action. When indicated, opium was given in large doses; but it was often contraindicated for sleeplessness, if after taking it the patient should awake with increased excitement. Camphor was much used, and often

[1] American Journal of Insanity, Vol. 51, p. 15.

combined with liquor ammoniæ acetatis, and was regarded as a valuable remedy.

Counter irritation was still prescribed to some extent. It is to be presumed that some in America followed an English authority of the time, and regarded blisters as beneficial in mania as revulsives, and as useful in melancholia by their irritation serving to divert the mind from its morbid train of thought. It was considered injurious to apply them to the head, as they increased the excitement of the cerebral membranes and interfered with the application of cold. Tartar emetic ointment and the like were used to maintain a steady counter irritation on the back of the neck in recent cases of insanity. Cold to the head, the douche for the same purpose, the warm bath with friction of the lower extremities, were prescribed in appropriate cases. But the use of cold water was regarded as requiring caution, and unjustifiable as a mode of punishment.

In the search for data as to the practice of American alienists in the use of medicine during the last half-century, the case-records for 75 years of the McLean Asylum have furnished a mine of information. The general results of their examination in detail will be given here, as probably affording a fair example of American practice and showing the changes in it.

In the period from 1840 to 1850 these records confirm the indications of the foregoing summary of the therapeutics of the time, except that there is proof, by negative evidence, of Dr. Bell's statement, already quoted, as to the disuse of "violent derivations." Tartar emetic ointment, applied to the spine, is once mentioned. A common tonic was "red mixture" (conium and carbonate of iron). Quinine, arsenic, port wine, "brandy and bark" were prescribed. Chloric ether was sometimes given in agitated melancholia. Tincture of opium in one drachm to three drachm doses was prescribed for the excitement of mania and sometimes in melancholia. It is noted in a case of puerperal insanity that "a previous attack seven years before had doubtless been prolonged by depletory treatment—bleeding, blistering, salivation and starvation." It is interesting to note the use, in a number of cases, of inhalations of ether and chloroform to allay excitement and promote sleep. "Supporting treatment," with nutritious and liberal diet, was the regular practice. The writer recalls with interest his personal experience in the preparing and dispensing, as a junior officer at the Hartford Retreat, about 1860, of a very similar list of medicines. The terms "red mixture," "elixir pro" and "nux and gentian" are vividly remembered, as well as the consistent teaching and practice of the "supporting treatment."

Moral treatment was regarded in all the asylums as of the greatest value. Taking the practice of the McLean Asylum as an example of the views prevalent from its beginning, in 1818, to 1850, its records show that great attention was paid to occupation and recreation. Dr. Bell gave interesting accounts in his reports of the means for inducing patients to take exercise, in manual labor on the farm and in the carpenter's shop, walking in the gardens, excursions, in-door games, entertainments, etc. These methods were not unlike those employed in hospitals of the same class at the present day.

At the McLean Asylum, up to about 1865, there is little change noted in the records beyond the introduction of new preparations of iron, the occasional use of strychnia, etc. But in that year bromide of potassium appears as being prescribed for melancholia. The use of opium and morphia at that time had notably diminished to small doses, often combined with hyoscyamus; and these prescriptions were much less frequent. Chloral hydrate appears among the drugs given in 1871; but before 1890 this and the bromides were practically no longer prescribed. Cannabis indica was given for a time, about 1880, but was quite abandoned, along with all preparations of opium, except codein, which was used in the restlessness of elderly people to allay distress, and in some cases of melancholia. During the latter period the newer preparations of iron, quinine, strychnia, etc., were commonly given. A rather increased use of stimulants at one time yielded to the more common practice of frequent feeding, especially at night.

The therapeutic history of the last five years or more of this hospital shows an extension of the indications just noted; there was also a marked lessening of the use of hypnotics. Paraldehyd and urethane were not long used. Sulfonal then came in vogue, but after three or four years was practically disused as unsatisfactory because of its possible after-effects; it still appears to be used in many hospitals, but there is evidence, in cases that come to them, that this and other like drugs are employed to excess. Then came chloralamid and trional, and these last are still prescribed for brief periods in severe cases. Hyoscyamin and the like were never used here beyond a few experimental doses. The same is true of hyoscin, although it is perhaps generally regarded as a useful drug. But gradually the practice has come to be the dependence upon food as the best tonic, and the best hypnotic, frequent feeding by night-nurses, with the warm bath as an adjuvant. A few sleepless nights were not regarded with anxiety, nor even a long continuance of small amounts of sleep nightly, as long as nutrition is maintained, as it more surely is when no poisons are given that impair the digestion and aggravate irritation by their after-effects.

After 1880 there was noted the increasingly diligent use of massage, sometimes faradism, and gentle gymnastics, with increasing amounts of exercise as it was borne. Absolute rest in bed in appropriate cases was prescribed, except when unendurable because of distressing restlessness; but such rest was insisted upon, and modified to suit the case—till after midday, or after breakfast. The practice of this later period may be summed up as the further development of the "supporting treatment" that our fathers began early in the century.

IV.

NON-MEDICAL TREATMENT OF THE INSANE.

It seems appropriate in this connection to make full mention of Brigham's views in reference to what he termed the *moral treatment of the insane*, that is, their treatment by measures other than medical.[1]

He dissents absolutely from the directions given by Dr. Rush[2] as to the care of the insane and says that they cannot be a correct guide. In his opinion a prevailing error in Rush's views is the belief that those in charge of the insane must obtain control over them by fear or by other equally improper means. Rush says, for example, "the first object of a physician when he enters a cell or chamber of the average person should be to catch his eye and look him out of countenance." Again, "the conduct of a physician should be uniformly dignified to his patients, if he wishes to acquire their obedience and respect. He should never descend to levity in conversing with them. He should hear with silence their rudeness or witty answers to his questions and upon no account ever to laugh at them or with them." After enumerating the various means for making insane persons obedient, Rush continues: "If these prove ineffectual to establish a government over deranged persons, recourse should be had to certain modes of coercion."

It is interesting to notice that among the methods of coercion are the straight waistcoat, the tranquilizing chair, the deprivation of customary pleasant food and pouring cold water under the coat sleeve so that it may descend to the arm pits. If these methods fail of the intended effect, Rush regarded it as "proper to resort to the fear of death."

With these views Brigham entirely disagrees, and he quotes with great approval the remarks of Dr. Wyman, the first physician and superintendent of the McLean Asylum, as follows: "In mental disorders where there are no symptoms of organic disease a

[1] Moral Treatment of Insanity, Am. Jour. Insanity, p. 1, Vol. 4, 1847.

[2] Observations on Diseases of the Mind.

judicious moral management is most successful." This moral management "should engage the mind and exercise the body; as in riding, walking, sewing, embroidery, bowling, gardening and the mechanical arts, to which may be added reading, writing, conversation, etc. The whole to be performed with order and regularity." He says that "even the taking of food, retiring to bed, rising in the morning at stated times, and conforming to stated rules in almost everything, is a salutary discipline."

Some ten years before Dr. Todd, of Hartford, to use his own words, made "the law of kindness the all-pervading power of the moral discipline of the Retreat and required unvaried gentleness and respect to be manifested towards the inmates of the institution by every member belonging to it." This course of treatment was wholly opposed to the recommendations of Rush, and Todd showed much skill and tact in securing its general recognition in this country.

Brigham regarded bodily labor as one of the measures necessary for the moral treatment of the insane and in the article mentioned above he expresses the hope that in the future, arrangements will be made by which the inmates of insane institutions will be better able to avail themselves of this means of cure. He laments the fact that some institutions at that time had insufficient land and no work-shops and states his belief that every institution should have a good farm attached to it, which alone, however, he considered was not sufficient. He thought that work-shops also should be connected with every institution, in which dress-making, tailoring, basket-making, shoe-making, painting, printing, bookbinding and other employments might be carried on by patients who could not be employed on a farm. But though he believed bodily labor to be useful, he regarded it as less curative than mental occupation. Manual labor he considered beneficial because it engages the attention and directs the mind to new objects of thought, but he feared that in some instances, especially in convalescence from acute disease, it might do harm and produce mental excitement. He believed that manual labor was most useful with incurable patients, since by preserving the health and arresting the tendency to mental impairment it rendered their condition more comfortable. With curable patients, on the other hand, he considered mental occupation more beneficial, especially

employing the mind in pursuits which engaged the attention, suggested new objects of thought, and enlarged and improved both the mental and moral powers.

Institutions, he thought, should be supplied with books, maps, scientific apparatus and collections in natural history. Schools should be established in every institution, where patients could learn reading, writing, drawing, music, arithmetic, geography, history, philosophy and the natural sciences. These schools should be in charge of intelligent instructors, who would give all their time to the patients, eating at the same table with them, joining in their walks and recreations, providing them with amusement, and undertaking no labor or duty except that of interesting those under their care and contributing to their happiness by conversation and companionship. They ought not to have anything to do with coercive measures, in order that patients may not be prejudiced against them and become ill at ease in their presence. They should encourage the timid, comfort the despondent and contribute to the cheerfulness and contentment of all.

He believed that schools were especially useful in arousing patients and calling into exercise the faculties of the mind which were becoming dormant and inactive. He would have all such patients devote a portion of the day to study with a view to mental development. He also believed that the melancholy and despairing, as well as all who suffered from delusions, or were restless and nervous largely from lack of occupation, were frequently cured by mental occupation, such as school exercises, writing compositions, uttering declamations, acting in plays, etc. In his opinion a lack of mental occupation was the great fault in modern institutions for the insane. While walking, riding, etc., soon became mechanical, and therefore furnished but limited enjoyment, attending school, he believed, provided mental occupation which, by requiring attention and effort, really interested the patient. He laid special stress upon the benefit to be obtained from a museum or a collection of minerals, shells, pictures, specimens of architecture or of modern art, and curios of all kinds, as calculated to engage the attention and stimulate mental effort.

It is evident that Brigham, in this respect, was far in advance of his time, and possibly of any time.

The most ardent supporter of the restraint system was probably the well-known Isaac Ray. His views may be found in the second volume of the *Journal of Insanity,* which contains an extract from a report presented by him upon the use of mechanical restraint, in which he argues that the interests of the insane do not require the disuse of all restraint and declares it must be proved either that restraints are positively injurious to the patient or that their intended object can better be obtained in some other way. Neither of these facts, he says, has been established to his satisfaction. He has no hesitation in saying that mechanical restraint is far preferable to the vigilance or force of attendants and is far less annoying to the patient. The mechanical contrivance, he says, "performs its office steadily, uniformly, thoroughly, and is submitted to as something inevitable." The vigilance of attendants and the exercise of their wills are capricious and variable.

There could be little doubt that his view in this respect is correct, if the only substitute for mechanical restraint in the management of an excited patient is to hold him constantly by the hands of an attendant. But Dr. Ray evidently fails to appreciate the usefulness of supplying some other means of employing his energies by walking or labor, or some occupation requiring the exertion of muscular strength. He goes on at great length to speak of the irritating character of manual restraint and praises the use of a simple leather strap whereby the patient is gently held upon his bed, but is able to turn from side to side, and of the muff or mitten which enables the patient to control his own bodily movements with perfect safety.

He does not endorse the statement that the application of mechanical restraint is liable to abuse and often leaves disagreeable impressions on the mind of the patient, and he expresses the belief that if restraining apparatus is applied by order of the medical officer alone, as is the case in his institution, and is used no longer than it is absolutely necessary to control the patient, it ministers to his comfort.

In discussing the extent to which restraint is in use, he states that the actual number of persons under restraint in his institution daily may at most amount to four or five, but that the average number does not probably exceed two or three. It is evident from another portion of his argument that the question of economy

entered somewhat into consideration. To furnish sufficient nurses and attendants to care for patients without restraint would seem to him to require a large increase in the number of attendants. "And thus," he says, "the expense of the establishment would be swelled to a very onerous amount."

In an elaborate and highly interesting article published somewhat later, Ray describes the European institutions for the insane, enters very fully into the question of restraint and non-restraint and shows the beginning of the movement in favor of restraint which developed later in the United States.

He regarded mechanical restraint not simply as a choice between restraint at the hands of attendants and restraint by means of an unyielding impersonal agency, but rather as a curative measure. In his opinion, the institutions of Great Britain were not as comfortable as those of the United States and he states that in his visit he detected many evidences that non-restraint did not accomplish the good claimed for it by its advocates. He recognized with some surprise the greater quiet of the European institutions as compared with those of the United States and ascribes it to the fact that the inmates were from the pauper class, a class entirely unknown in the United States. "We have no poor," he says, "supported by public charity. What I mean is that our poverty is a casual condition, a temporary misfortune, the result of accident, disease or mischance, and dies out with its unfortunate subject." He believed that the poor patient in the American asylums is by nature fresh and buoyant, with his energies in full vigor, and that consequently, when put into an institution he became restless, uneasy and anxious to be relieved of all personal restraint. While there may be some weight in Ray's argument, it is evident that he did not approach the subject with a wholly unbiased mind and was inclined to defend the use of restraint in America as more or less a matter of patriotism.

It is evident, however, that, as the result of discussions appearing in many of the annual reports of superintendents of institutions for the insane, a feeling grew up that mechanical restraint was a curative agency, the use of which, though it might be abused, was preferable, in spite of its faults, to its entire abandonment.

Another element in the increased use of mechanical restraint was undoubtedly the fact that institutions grew and enlarged

beyond the original intention of those in charge of them. The superintendent's time and energies were claimed not only by his professional duties but by others of a non-professional character, such as the care of the farm, the kitchen and the laundry, to say nothing of numberless outside affairs which devolved upon him because of his prominence in the state and his public-spirited citizenship.

Under these circumstances, it is plain that the work of caring for the patients had to be more and more delegated to others and the pinching economy which characterized the management of the early institutions for the insane unfortunately kept the medical staff down to the lowest point. The physician-in-chief was theoretically supposed to do everything and the number of his assistants was very limited; often, indeed, he had but one, whose duties were as varied as those of his chief. As a result of this state of things, it became necessary to transfer more and more of the personal control of the patients to lay under-officers, such as matrons, supervisors, head attendants and the like, a condition of things which induced increasing latitude in the use of restraining apparatus. Patients were often violent or destructive, and as their condition was not then fully understood, and their destructive habits were the cause of serious expense to the institution, many superintendents considered it essential to employ restraining apparatus.

We now know that this system tended to beget additional demand for restraint. Mechanical restraint being easily applied, and not requiring much personal exertion on the part of physician or nurse, came to be regarded as a panacea for many unpleasant features of insanity. Unfortunately, as has often been pointed out, the influence of the use of restraint upon the patient himself was not sufficiently considered. The statement was made again and again in the published writings of the early members of the Association as well as in their discussions that lack of self-control was the most prominent feature in mental disease, and that when self-control was restored most of the unpleasant features of insanity disappeared. It was consequently very easy to jump to the conclusion that if a violent patient was restrained his powers of self-control were in a certain way increased, but it was forgotten that self-control comes from within and not from outside methods.

Hence, in the majority of cases the patient who had an imperfect appreciation of his own condition misunderstood and misapprehended the object of restraint. It was impossible, in the majority of instances, for him to regard it as anything else than a punishment and an interference, if not an indignity, which he felt he did not deserve. Unquestionably this conviction was frequently impressed upon his mind by those who had him in charge, who usually threatened that if he did not exercise self-control and refrain from acts of violence he would be placed in restraint. Whatever motive might originally have actuated the physicians in charge or the officer to whom the authority to apply restraint had been delegated, it is undoubtedly true that in the majority of instances patients and their attendants both regarded the application of mechanical restraint as a species of punishment or at least as a penalty for a lack of self-control. Consequently there grew up in the mind of the patient a feeling of resentment, and unquestionably habits of violence, destructiveness and morbid tendencies in various directions were rather cultivated than repressed by the application of mechanical restraint. Those who came into institutions a generation or two later found a large number of patients whose condition was deplorable. They were noisy, destructive to clothing and furniture, untidy in their habits, and incapable of employment, because of more or less constant seclusion and restraint. The effect of all this was to engraft upon the system of care which prevailed generally in early institutions a false method, which finally extended to nearly all the institutions of the country. Instead of restraint being regarded as a necessary evil, to be used only in the most serious emergency, it came to be looked upon as a necessity in the growth of institutions and the consequent increase not only in the number of patients, but in the number of unskilled and untried medical men entrusted with the care of them. Under these conditions the use of mechanical restraint was upheld and defended as a salutary measure essential to the successful and proper treatment of patients.

The years 1860 to 1880 marked the high-water mark of the tendency to employ mechanical restraint. The use of it was lauded by many superintendents as one of the most beneficent means of treating the insane, and the good condition of the institutions in the United States where restraint was practiced was contrasted with

the deplorable conditions in England where restraint was not permitted and could only be used in the most stringent emergencies. At length, however, it became apparent that the development of industries in institutions and the introduction of employment, amusements and open air life had a marked effect in quieting patients and promoting their morale; while under these influences the unpleasant forms of insanity, which had been supposed to require restraint, but had really developed under it and in many instances been created by it, were found to disappear. Patients who had been supposed to be more excited or violent or outrageous generally than English patients, because of the greater excitement of the climate of America, were discovered to be very much the same as insane patients in England, and it became plain that a change in the type of the insane had in reality been produced by faulty methods of care and treatment.

We now know that the evils of non-restraint were exaggerated and the curative influences of mechanical restraint were unduly dwelt upon. There is little doubt in the minds of those who were familiar with institutions for the insane 40 years ago and who see them at the present time that the abolition of mechanical restraint and the substitution of prolonged baths, occupations, amusements, exercise in the open air and personal care have effected a great change in the type of mental disorder and that insane patients are in every way more comfortable than they were in former times, and above all that the relations between the nurse and the patient have vastly changed for the better.

V.

EMPLOYMENT FOR THE INSANE.

It is evident from an examination of reports of earlier institutions for the insane that their medical officers had an excellent appreciation of the benefits of employment, recreation and proper amusement.

The importance of schools was early recognized by those who were engaged in the organization of the first institutions for the insane. They were considered a form of so-called moral treatment and were beneficial as we know now, because they furnished a system of re-education. Among the earlier patients under treatment there were many who, owing to pioneer conditions, had few opportunities to acquire the simplest form of education. Consequently simple school exercises were great advantages to them when they were convalescent from mental trouble, usually an attack of excitement, because such was generally regarded the only form of insanity which required hospital treatment in early days. To such patients, regular, systematic instruction in the simplest rudiments of education, like reading, writing and arithmetic, was extremely beneficial, because it gave not only occupation but also healthful exercise for the mind in a way which did not overtax it. These exercises grew more difficult only when the patient's education and mental vigor had increased, so that there was little danger that he would become fatigued or exhausted by excessive mental labor. In the later schools for the insane the mistake was sometimes made of prescribing studies which were too difficult, and in some instances patients broke down while endeavoring to pursue them. One of the most interesting accounts of such schools for the insane is given in Volume I, page 326, of the *American Journal of Insanity*. This describes the routine pursued in the New York State Lunatic Asylum. The subject is continued in Volume II, page 284.

The Utica State Hospital and the Hartford Retreat were pioneers in the introduction of schools and employments as curative agencies, and in the first number of the *Journal of Insanity* Dr. Brigham gives an account of the efforts then made to employ

patients as follows: "Attached to the asylum at Utica is an excellent farm, where the patients in good weather perform much labor and also in the garden, by all of which they are much gratified and improved. Some work in the joiner's shops, some make and repair mattresses, and others work at making and mending shoes. The women make clothing, bedding and do the ironing and assist in various household duties. They also manufacture many useful fancy articles for sale." He goes on to describe a fair that had been held a month before for the sale of articles manufactured by patients at the asylum and quotes from a daily newspaper a passage showing how every one was surprised at the beauty of the fabrics and the skill and ingenuity displayed in their manufacture. There were dolls of every dimension, baskets, caps, stockings, gloves, aprons, collars, bags, purses, etc., in abundance.

Schools for both sexes had been established from which good results had been obtained. The winter session of the school had been closed by an exhibition at which there had been given original pieces, recitations, music and original plays which would not have been discreditable to any literary institution.

In giving an account of the daily routine of the asylum, after mentioning the hours of rising, of meals and of house work, he speaks of those patients who are permitted to labor on the farm, in the garden, about the halls and yards or in the shops, and says that many more usually volunteer to engage in work than it is deemed prudent to employ. "Those who do not labor," he says, "pass their time reading, playing ball, rolling nine pins, in walking or attending school. The women work much of the time; they also take drives, walk, play battledore and attend school."

In a following number of the *Journal of Insanity* he gives a description of the school at the Utica State Hospital. "There are," he says, "three schools for men, one managed wholly by a patient, the other two by a teacher hired for the purpose, and one school for women conducted by a hired teacher. School sessions commence at 10 in the morning and at 3 in the afternoon and each session continues for one hour. They were opened and closed by the singing of a hymn. The patients read, spell, answer questions in arithmetic, geography and history and are assisted by blackboards and a globe. The majority commit pieces to memory and once in two weeks there is a meeting of all the schools in the chapel, when they

unite in singing, which is followed by declamations, reading and compositions. Some patients have learned to read and write at these schools. Several who were depressed have been much improved by attending school and a considerable number who were approaching a demented state have been improved in mind and have become interested in learning."

In a later article an account is given of the establishment at the Utica State Hospital of what are termed "whittling schools," in which, "in addition to carved reproductions of all ordinary objects, such as houses, temples, ships, chains, etc., as well as all four-footed and two-legged and creeping things, there were many works of pure imagination presenting strongly marked characteristics of the *asylum school.*"

The theory held by Dr. Brigham and also by Dr. Todd, of Hartford, was that employment, to be of benefit to the patient, should not consider the question of gainful occupation. In their opinions it should be of a character to divert the patient from his morbid fancies, to engage his attention, stimulate his interest, and lead him to resume natural and healthy methods of thought and of occupation. Hence Dr. Brigham advocated the establishment of the "whittling shop," mentioned above, and also made plans for a printing office and other smaller industries in connection with his institution. He spoke repeatedly of the advantage of household occupations, such as gardening and flower raising for women, with out-of-door labor, upon the farm and garden or about the building, for men.

It will be observed that these schools were a part of the hospital routine. As long as Dr. Brigham continued superintendent, and during the superintendency of Dr. Benedict, his successor, they continued in operation. Under the superintendency of Dr. John P. Gray they were discontinued, and in a discussion in the Association in after years he assigned as a reason for their discontinuance that they had proved too monotonous; and declared that other forms of amusement and occupation were better suited to convalescent patients. Dr. Gray probably generalized too widely from insufficient data. One of his assistants, Dr. J. B. Andrews, when he opened the Buffalo State Hospital later organized a school which has been in regular operation ever since and has proven of great service to patients, especially to those who had received an imper-

fect education or who had been born in a foreign country and desired to acquire a knowledge of English. We have no means of knowing how generally schools were employed at first for the education and diversion of patients, but they seem at one time to have been quite common.

At the New York State Lunatic Asylum, in addition to the regular studies of the school, a schedule was adopted by which on two evenings of the week the patients listened to reading; on two other evenings there was card playing, and on the fifth evening dancing, in which the patients participated. There was also a weekly lecture in the afternoon and entertainments in the amusement hall, such as concerts, theatricals and social events.

In the matter of out-door employment there were games of ball, quoits and battledore. The women engaged in drawing, painting, dancing, music and sewing. The men were employed in farm labor. The school hours were from 10 to 11 a. m., and from 3 to 4 p. m.

In a recent personal communication Dr. Mary Lawson Neff, who had long directed occupations and amusements in the institutions of Massachusetts, reports that out of 60 institutions which she had visited, only one retains its school.

On the other hand Dr. Eyman, of Massillon State Hospital, Ohio, gives the following interesting details respecting his school:

> During the past year a school has been in session at this hospital. Through a private donation a sum of money was obtained sufficient to purchase the material, and, under the direction of the superintendent, the work of construction was practically done by the patients. The building is brick, two stories in height, with a basement; the dimensions are 45 by 86. It is in a sightly portion of the estate, on the edge of a hill, and below it is an open field for tennis courts and baseball. At each end is a wide porch and a wing, with stairways leading to the basement. The basement accommodates billiard tables and a bowling alley. The first floor contains two rooms separated by a single hall; one is the library and reading room and the other is a class room. The second floor contains a single large hall which is used as a gymnasium. The room is supplied with electric lights and is heated by steam.
>
> Two teachers are provided for the school and about 100 patients per day are in attendance. Three sessions are held daily, two for women and one for men. The subjects are oral arithmetic, reading and spelling. The patients, in addition, are encouraged to relate stories and incidents from their experience bearing on whatever subject is under discussion. There are also spelling contests and special recitations and songs. Free-hand

drawing and the study of German have also been introduced, and special classes in history and geography have been formed.

Each session begins with opening exercises, consisting of songs and piano music, followed by a talk on some subject of special interest, or the teacher may read to all an interesting story. There is a general feeling of willingness to engage in school work, but very naturally the conditions are somewhat like those of an ungraded school; many patients who are unable to take any active part are contented to listen and seem to enjoy the companionship and work of others. Others also are timid and require special effort to put them at their ease until they are able to take a part with the others. It has been the aim of the superintendent of the hospital to make an appeal to the patients to recall and reproduce as vividly as possible their former school days, and to awaken and stimulate early associations, with the hope that the stream of thought may thus be brought back to a natural channel. For this reason the school is an old-fashioned school and the text-books used are of the old type. An effort is made to vary the instruction and to give a sustained interest to the exercises. The questions and subjects are simple in character and the patients are encouraged to speak of the experiences and ideas which the lessons suggest to them. The last 20 or 30 minutes of each session are given to calisthenics in the gymnasium, beginning with a simple march to music and followed by a simple gymnastic drill, with definite commands and without apparatus. At the close of the drill the patients join in old-fashioned games, like drop the handkerchief, London Bridge and fox and geese.

In addition to the special work of instruction, patients are permitted to come to the library to play games, to read the newspapers and magazines and to write letters. There is also a piano in the school room and the music for the exercises is furnished by patients.

In the matter of occupation it is interesting to notice that many institutions now have separate buildings for occupations and recreations. There are occupation rooms at Warren, Pa.; at Northampton, Mass.; at the Friends' Hospital at Frankford; at the Sheppard and Enoch Pratt Hospital, Maryland; at Harrisburg, Pa., and in many other similar institutions. In Northampton, Mass., it is interesting to recall that under the superintendency of Dr. Pliny Earle some form of amusement was presented to the patients every evening in the week, attendance upon which was voluntary. There was, however, a moral compulsion on the part of the patients to go, because they appreciated the fact that it was much better to sit in a well-lighted, well-filled amusement hall with good company than to remain in a lonely ward with comparatively few associates.

In the matter of employment, it is interesting to notice an early report from Dr. Stribling, of the Western Lunatic Asylum, at

Staunton, Va., in which he urges that the directors purchase slaves as necessary to the successful operation of the asylum, "because," he says, "the services of slaves cannot be dispensed with." This would seem to indicate that little was attempted in the way of labor on the part of the patients.

In the report of the South Carolina State Hospital, on the other hand, some excellent observations occur on methods of employment to influence the brain to resume its healthy functions and to return to its normal state. Dr. Trevezant, the superintendent, says: "But how is the attention to be fixed and the mind employed and morbid ideas replaced but by pleasant conversation, exercise, steady and sustained employment?" He goes on to mention the custom prevailing in Northern institutions of keeping the patients employed at some trade on the farms and thus giving them full exercise and something to occupy their minds so that they are compelled to think, their feelings and their thoughts are diverted from the sources of misery and distraction which had shattered their intellectual powers, and asks, "But what course is to be adopted with those who will neither work nor engage in amusements?" To this question he replies: "I have no hesitation in saying that they should be forced"; and cites as example the discipline used for the sick and the exertions which children are compelled to make to their own advantage. Dr. Trevezant also seems to appreciate the fact that many patients who cannot be induced to work and have been permitted to lounge about have become imbeciles and lost the little intellect they possessed. He inquires whether means can be devised to compel them to take exercise without using punishment or violence or coercion. He believes that such means can be devised and urges the Board of Regents of the hospital to furnish him with proper recreation for the patients and to supply them with proper work and expresses the hope that "you will not permit your feelings to get the better of your judgment and prevent the establishment of such means as will furnish involuntary and compulsive labor to those who would otherwise be idle, and that it be continued until the beneficial effects are no longer necessary."

Dr. Trevezant seems to have been a physician far in advance of his time, but it is doubtful whether the regents of the hospital did give him the means which he desired for recreation and proper work.

During the " restraint " period which later developed in American institutions the systematic employment of patients was carried on fitfully and unsatisfactorily. Many states possessed but a single state institution for the treatment of acute cases. As soon as a patient had attained some degree of health, or if a chronic case had acquired sufficient self-control to leave the institution, it was customary to return him to his friends, or to the county almshouse or asylum in order to give place to a patient in an acute stage of his disease. This comparatively rapid movement of hospital population deprived the state institution of the opportunity to develop any fixed or settled employment for patients as a class.

Later on, labor in household duties in the wards, in the gardens and about the grounds was attempted and in many instances successfully accomplished, but such labor fell almost wholly upon chronic cases who for various reasons had been retained in the institution. With the development of non-restraint methods it became essential to supplement household duties by occupations and industries calculated to interest and engross the attention of all classes of patients, acute as well as chronic.

Among the earlier industries which unquestionably proved of great service to patients during the stage of convalescence the first place should be given to ordinary farm labor, such as feeding cattle, milking cows, and other agricultural operations which the majority of patients from the rural districts pursued at home. In institutions established in the newer sections of the country large numbers of patients have been employed in clearing and grading grounds and in the wheel-barrow work necessitated by excavations and new roads. In a few institutions brick-making was developed as an industry, patients being engaged in excavating the clay, tempering and mixing it and afterwards moulding it into bricks which were subsequently burned and used in the construction of additional buildings. This was done in Virginia, Idaho and other states. In Long Island, at Central Islip, a large number of patients were employed in clearing land, removing trees and brush and in making roads. It is an interesting fact that many patients who have been thus usefully and profitably employed, both for themselves and for the institution, had not been accustomed to out-of-door labor in any form prior to leaving home. They were city-born and bred and many had been tailors, artisans, mechanics and

frequently piece workers, whose work had been wholly done by hand in the shop or at home. It was found that no class of patients showed more interest and enthusiasm in out-of-door work or received greater benefit from it.

During the period from 1870 to 1890 there was a large development of indoor industries in connection with the various state institutions. These took the form of manufacturing boots and shoes, clothing, brushes, carpets, mattresses and furniture, as well as type setting, all of these being in-door trades. The development of out-of-door occupations has been regarded as upon the whole more satisfactory, because they generally bring an ample return to the institution. If the large amount of labor available in institutions for the insane were applied to a systemized industry it would unquestionably produce large results from a manufacturing standpoint, if that alone is worthy to be considered, but there are serious difficulties in finding a market for the product. It might, in fact, require legislative action to compel all state institutions to purchase articles thus manufactured, as is the case in New York in connection with prison industries. Those most familiar with industries among the insane are doubtful as to the development of industries in institutions beyond those required to supply the necessities of the institutions themselves.

Experience has shown that industries which contribute directly to the patient's improvement in health, strength and mental vigor have a direct curative influence and that occupations from this standpoint can be advocated and should be maintained as a direct curative measure. Where, however, the question of gainful occupation enters in, there is reason to fear that the well-being and cure of the patient may not always be properly regarded; hence the majority of superintendents believe that it is preferable to employ patients in the open air, in such labor as directly lessens the expense of the individual institution rather than in any form of commercialized industry.

All agree that forms of occupation should be suited to the strength and capacity of the patient, and that they should be employed under the direction of a physician.

In some states a law exists whereby authority is given to medical officers of institutions to give employment to patients solely as a mode of treatment. This has apparently worked well.

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VI.

ASYLUM PERIODICALS.

The first asylum periodical was issued under the following circumstances: In 1837 one of the patients of the Hartford Retreat, who had been a printer, and also an editor, repaired to one of the printing offices in Hartford, and with the assistance there obtained, issued two numbers only, of a little sheet called the *Retreat Gazette*. He remained under treatment for some time, and was discharged without being restored.

"The *Asylum Journal* was the first regular newspaper ever printed in and issued from a lunatic asylum." It was published and printed at the Vermont Asylum for the Insane, located at Brattleboro. Its first number bears date November 1, 1842. It was originated by a young man seventeen years of age, a printer by trade, who was admitted to the asylum, July 15, 1842, and the general management of it was almost wholly in his hands during the first two years. Other inmates, however, contributed to its columns; it was a weekly, single sheet, ten by twelve inches in size. The terms were one dollar per annum, and the profits were to be applied to the support of the indigent insane at the asylum. It bore the appropriate motto, "Semel insanivimus omnes." "We have all, at some time, been mad." It claimed as its object the dissemination of correct views of the condition and proper treatment of the insane. On the first of January, 1843, the price was reduced to fifty cents per annum, and was so continued for two years. At that time, as several who were engaged in its printing were "considered by the majority of mankind to be sane" and left the asylum, the *Journal* was issued only monthly, and the price was reduced to twenty-five cents per annum. After two years, covering a total existence of four years, it was suspended. Of the pecuniary aid toward supporting the indigent insane, we cannot speak, but a substantial benefit to the patients and the institution was derived from its list of exchanges, which exceeded two hundred in number. In his report for the year 1847, Dr. Rockwell observes: "The printing of the *Asylum Journal* has been discontinued in consequence of the recovery of the printers, who have left the asylum."

The next asylum periodical in this country was the *Opal*. This was printed and published at the State Asylum at Utica, N. Y. It was begun on the 1st of January, 1851, issued monthly, in newspaper form, a double sheet, ten by twelve inches, and furnished at fifty cents per annum. Its motto was "Devoted to Usefulness," and its object to increase the library of the institution by the profits, if any accrued, and to extend a knowledge of "our" wants to a generous public who can but be interested in "our" welfare. From the report of the institution for 1851, we learn that during the first year of its publication it had "an exchange list of two hundred and twenty weeklies, four semi-weeklies, eight dailies and thirty-three monthlies, and that the number was still on the increase." It was continued in magazine form, double its former size and subscription price. In 1852 its exchange list was increased to over three hundred newspapers and periodicals, and the subscription fund furnished an addition of several hundred volumes to the library. In 1854 it is reported that the proceeds from the *Opal* and from the ladies' fair amounted to four hundred dollars, which were expended in books, improvements to the green house and in amusements. In 1855 the amount derived from the same sources was six hundred dollars, which were used to purchase an oil portrait of Dr. A. Brigham, the former superintendent, and a piano. The report for 1857 contains the last reference to the *Opal:* "From our printing office are regularly issued the *Opal* and the *American Journal of Insanity*. The former, a monthly of twenty-four pages, now at the close of its seventh volume, is entirely original, and the production of the patients. . . . . The large number of newspapers and magazines received in exchange furnish abundant reading matter for the entire household. The programmes for our entertainments and concerts, blanks, book labels, etc., are printed in the institution. In the building attached to the printing office, all of our exchanges and pamphlets are bound, and the successive issues of the *Journal* and *Opal* are stitched and prepared for mailing." In appearance, the *Opal* compared favorably with the various subscription magazines. The first page of the cover was ornamented with an engraving of the illustrious Pinel; the paper was good, the type clear, and the character of the articles interesting. It closed its career with the third number of the tenth volume. We quote from the valedictory: "We believe the world is wiser, if not better, for our *Opal*.

It has cleared up so many doubts, dissipated so many errors and wrong opinions concerning monomania and insanity. It has taught outsiders how little difference in ideas there often is between those within and those without the walls. It has shown how very difficult it is to tell where melancholy ends and insanity begins: how narrow the boundary between eccentricity and lunacy, and it might tell how much better insane people behave under the asylum code of etiquette than the world's votaries often do.

"It should have taught them that not a multiplicity of cares or anxieties is the chief agent in bringing about such mournful results, but the same enemy to peace,

> 'Which crazed King Lear,
> The continual racking of brain with one idea.'"

The success of the *Opal* during the first few years of its existence was marked and gratifying. A large edition was printed, and most of it was advantageously disposed of. This flourishing state was, however, of comparatively short duration. After a few years the novelty to the public wore off, subscriptions declined, and exchanges were discontinued. During the last three years an examination of the books, which were kept by an assistant physician of the asylum staff, showed that the receipts amounted to less than the expenditures.

Other causes were also operative; some of its best contributors recovered and were discharged; the editor, the printer and the binder, declined in mental power, from the progress of disease, and soon after died. The breaking out of the war in the Spring of 1861 turned the minds of all the household in that direction, and they became much interested in laboring for the cause of the soldiers. This took the place largely of the work formerly done upon the *Opal*, and of the fairs. The report of that year shows that the female patients and attendants employed their leisure time in sewing, knitting, or making lint for the soldiers, and that the men contributed $306.50 in money, which was largely expended for the material worked up by the ladies.

A long interval elapses before another newspaper venture was made in an American asylum.

The first number of the *Meteor* was issued in July, 1872, from the Alabama Insane Hospital. This was a quarterly, single sheet

paper, nine by eleven inches. It bore the motto "Lucus a non Lucendo." It was edited by a patient, and printed at the hospital by patients. Original communications only were received. Its edition of several hundred copies was distributed to papers and patrons of the hospital. "We have hauled down our subscription rates, and will in future receive no subscriptions for the paper" was also announced. The object of the paper "is to keep the press, the people of Alabama, especially the patrons of the hospital, *en rapport* with the doings of the institution, and well abreast with the most advanced views in the care and treatment of the insane." In the accomplishment of this purpose its columns were largely filled with news of events transpiring in the hospital, and items from other institutions collected from exchanges.

The *Friend* was the title of a paper of the same size as the *Meteor,* issued from the Pennsylvania State Hospital, at Harrisburg, and "conducted by an association of ladies." It commenced its existence as a monthly in September, 1872, and was published regularly till April, 1874. The subscription price was fifty cents per annum. It was a sprightly little sheet largely made up of short witticisms, many of them excerpts. Its brief existence and its early death leave us little to say, and this should be only good.

Many other ephemeral periodicals have appeared in connection with institutions which possessed the proper outfit for printing them, but the history of the journals sketched above by the late Dr. J. B. Andrews clearly points out the fate of these ventures. They prospered for a time owing to the industry and initiative of some one person who felt responsible for them and ceased to exist when by recovery or otherwise the individual passed from the institution.

VII.

INDIVIDUAL TREATMENT.

The abolition of restraint brought permanently to the attention of superintendents of institutions the necessity of treating each patient as an individual; it seems also to have become equally evident to nurses and employees that patients of every class require similar treatment if their condition is to be made comfortable.

The attitude of nurses towards patients was in fact greatly changed by the abolition of restraint. Every nurse soon perceived that the best method of dealing with a violent, destructive and possibly dangerous patient was to be on friendly terms with him and to make him comfortable. It became necessary also to understand his thoughts and feelings; to inquire why he was restless, apprehensive, or destructive; and, if he was violent, to determine how his excitement could be diverted from habitual violence or destructiveness into more healthful channels.

Women nurses soon endeavored to interest their patients in the decoration of wards, in household work, fancy work, knitting, sewing, braiding rugs, making toilet articles, assisting in laundry work, darning stockings, mending clothing and other familiar occupations of home-life. In some hospitals old-fashioned spinning wheels were purchased for the employment of elderly women in spinning carded wool. Looms were also established, and in certain institutions at the South cotton was spun, woven into cloth and afterwards made into garments.

Men nurses were equally zealous in studying the peculiarities of patients and in learning what employments and occupations were congenial. For a time there was a natural fear lest acts of violence might occur should patients be allowed free use of the facilities afforded and the implements required by their different occupations, but it soon became plain that dangerous tools could be placed in the hands of an insane patient with safety, as long as his energies were directed towards useful labor in which he felt an interest. Such individual study of each patient by nurse and physician had the advantage of securing a return of interest in definite forms of work, by which healthful trains of thought were

suggested, to the exclusion of morbid fancies leading to violent conduct. Such individual study and treatment of patients have been of much benefit to the insane. In many institutions nurses were required to make careful records of the hallucinations, delusions and strange actions of their patients, a practice which taught them to observe their charges more carefully and to appreciate that insane conduct always has behind it an insane motive and is not caused by depravity or a desire to outrage the feelings of others.

VIII.

EXPERIMENTAL REMOVALS.

It was found in some instances that patients developed delusions and strange fancies in connection with institutions where they resided, which consequently became unsuited to their curative treatment. This fact suggested to many superintendents the desirability of changing the patient's surroundings, or even of bringing him to his former place of residence, in order that he might compare his condition with that of his old friends and neighbors and thus ascertain whether or not he could adapt his ideas and conduct to his former condition of life and share in the activities and modes of thought which prevailed in his own community. This gave rise to furloughs or experimental removals from hospitals for the insane. In some instances such experimental removals were not followed by beneficial results and a return to the institution became necessary. It was frequently observed, however, that the patient came back in a more normal condition than when he went away; he appreciated the hospital better and understood his relations to the public as he had not before. Moreover, though he failed to adjust himself to his home during the first experimental removal, his experience often paved the way for a second trial, in which he went home to remain permanently.

In other similar instances a patient who returned home as an experiment was able to remain there, because during his stay in the hospital he had regained sufficient self-control to appreciate conditions which were not operative when he left his home. He perceived that unless he exercised self-restraint and did not allow his delusions to overcome him he would be returned to the institution. His desire to remain away from the hospital gave him an incentive strong enough to enable him to control destructive tendencies and to engage in industries which engrossed his attention and gave him a feeling that he had resumed his old place in the world.

In most states experimental removals have been conducted informally, selected patients being allowed to go to the care of interested and devoted friends, who become responsible for their

safekeeping with the understanding that they can return within six months or possibly one year without a fresh commitment should such return become advisable. The longer experimental removal is undoubtedly better than the shorter furlough. In some states a furlough of 30 days is allowed; in others one of 50 days; in still others one of 90 days; in several one of six months; and in a few states one of a year. It is probable that the majority of chronic patients who go away upon a furlough remain away permanently if the conditions of home life are satisfactory. In many instances, however, poverty, old age and the death of friends and natural protectors all conspire to bring about the return of a patient who might, under more favorable conditions, remain permanently at home.

IX.

ORIGIN OF THE PSYCHOPATHIC HOSPITAL IN THE UNITED STATES.

For many years, in fact until 20 years ago, the main idea which governed the erection, organization and management of hospitals for the insane seemed to have been to provide for the custodial care of patients. It is true that the thought of treatment and cure already occupied the minds of many medical officers and was assiduously dwelt upon in the reports of the different hospitals. Unfortunately in the minds of the majority the idea of cure became a relief of violent symptoms and was closely associated with the theory that it was to be accomplished largely by the use of mechanical restraint. For this reason it is not strange that in many institutions the custodial features of the work assumed undue importance, and the medical treatment of insanity was neglected.

Between 1880 and 1890, however, many medical men went abroad and learned from practical observation the beneficial results of non-restraint. When they returned to their own institutions they saw the importance of dividing the two classes of the insane, the feeble, depressed and exhausted class from the robust, stout and active. Accordingly hospital wards, so-called, were set apart for the special care of the aged and feeble and those suffering from the more acute forms of mental disease. The remainder were for the most part cared for in old-fashioned wards, built on the Kirkbride plan, but such patients as were capable of active labor upon the farm were housed in cottages or other detached buildings, where it was possible for them to enjoy greater freedom and to lead a life approximating that of home.

Dr. W. B. Goldsmith, at the Danvers State Hospital, was one of the first to establish such hospital wards for the careful special treatment of acute cases, as in a general hospital. Similar wards were also constructed in Buffalo, Kankakee, Kalamazoo and Pontiac, Mich. Later they were used as reception wards for all patients admitted to the hospital.

In Buffalo in 1895 the reception ward grew into a new department known as the Elmwood Building, which has since been used largely for the treatment of acute cases of both sexes.

Following this, largely through the result of studies in Germany and especially through the writings and addresses of Dr. Peterson, subsequently Commissioner of Lunacy in New York, the desirability of the erection of psychopathic hospitals arranged for the treatment of mental diseases similarly to that of acute diseases in a general hospital began to bear fruit. Peterson's first publication, in fact, recommended the utilization of wards or departments of general hospitals so that mental disease might be treated by the same staff and under the direction of competent men, skilled in internal medicine.

About the same time Dr. L. Pierce Clark, of New York, who had become interested in the study of epilepsy, published an elaborate and instructive paper in the *American Journal of Insanity* on psychopathic wards in general hospitals and special psychopathic hospitals, which had much influence throughout the country. Dr. J. T. Eskridge of Denver also, in an address referred to in the "History of the Association," outlined his plans for the proper organization of a psychopathic hospital which called for internes and medical attendants of the same grade as in the best general hospitals, and a staff so numerous that each 50 patients should have one or more medical attendants.

One of the first pavilions or wards established for the treatment of mental cases in a general hospital was established in connection with the new General Hospital at Albany, N. Y. It was known as Pavilion F and was situated in close proximity to the main hospital building, but in such a location that the excited patients might disturb the rest of the hospital as little as possible. This ward was placed under the special charge of Dr. J. Montgomery Mosher, a skilled and experienced alienist, who has borne the burden of it during the past 14 years and by his skill, energy and thorough work has shown the feasibility and utility of a mental ward in connection with a general hospital.

About the same time, through the efforts of the late Dr. W. J. Herdman, of the University of Michigan, and with little or no co-operation on the part of other state hospitals, largely owing to the fact that the movement was initiated by persons who were not friendly to the state hospital system, the legislature of Michigan made an appropriation of $50,000 to establish a state psychopathic hospital in connection with the hospital of the Univer-

sity of Michigan. This hospital, owing to a variety of causes, was slow in becoming organized and did not attain complete success until it was placed under the charge of a board composed of the regents of the university and representatives from the different hospitals for the insane in Michigan. Since that time, under the admirable direction of Dr. Barrett, it has done excellent work in the care of recent cases and in the study and investigation of mental disease.

The State Psychopathic Hospital of Massachusetts was next in order of establishment, under the auspices of the State Board of Lunacy, as a department of the Boston State Hospital. Although nominally connected with the latter in its business management, it is practically independent. Its professional work is in charge of Dr. E. E. Southard, formerly pathologist of the Massachusetts state institutions. It enjoys an active service and receives nearly all committed cases from Boston and its vicinity. The medical staff is large; and valuable studies and research work in psychiatry are being prosecuted with great skill and success.

About the same time hospital wards were erected in the McLean Hospital, Waverly; Butler Hospital, at Providence; and Bloomingdale Hospital, at White Plains. These hospitals were provided with quiet, secluded wards, special rooms, facilities for hydrotherapy and mechano-therapy and all the essentials of a general hospital for the treatment of acute diseases.

There was also in connection with the lunacy service in the State of New York an extension of the State Pathological Institute, then under the care of Dr. Adolf Meyer, through the cooperation of Dr. Mabon, the superintendent of the Manhattan State Hospital, whereby several wards were placed under the charge and medical care of men connected with the pathological institute.

Later, through the liberality of Henry Phipps, of New York, the Henry Phipps Psychiatric Clinic, in connection with The Johns Hopkins Hospital, was built and endowed for a period of years for the care of hospital patients suffering from mental disease.

During the past three years legislation has been enacted in the State of Minnesota whereby each state hospital is required to establish a psychopathic hospital for the treatment of recent cases in that state.

There is an evident confusion in the mind of the medical profession as well as of the public as to the precise distinction between a detention hospital and a psychopathic hospital. In many instances the distinction is not made. In a few hospitals only the two functions seem combined. Thus, Pavilion F, of the Albany General Hospital, seems not so much a place of detention as of treatment, and, on the other hand, the psychopathic wards at Bellevue Hospital seem almost wholly places of observation and temporary detention, but not designed for treatment. The psychopathic wards at the Philadelphia Hospital are said to be designed both for detention and treatment. In reference to the Government Hospital at Washington, Dr. White writes:

> The reception wards at the Government Hospital for the Insane are, I think, properly speaking, psychopathic wards. The reception buildings for white male and white female patients are two large buildings of four wards, with a nominal capacity of 30 beds each. These buildings are well equipped; they all contain up-to-date hydrotherapeutic installations and operation departments; and we keep our best nurses there. The buildings are used largely for taking care of the acute sick who are sent there from the other portions of the hospital, particularly surgical cases. There is a reasonably well equipped reception ward for colored men and also for colored women, the latter having access to a hydrotherapeutic outfit. A similar equipment is now under consideration for colored men.

Detention Hospitals.

California seems to have been one of the first states to arrange what may be termed a system of detention hospitals for the insane who are awaiting admission to the state hospitals. In Los Angeles a large reception hospital has been erected and maintained by the county and city, although under the inspection and supervision of the Lunacy Commission and placed in charge of a physician experienced in mental practice. This hospital receives practically all insane persons who are taken up for examination, or are detained for treatment or who need to be under strict medical observation after discharge. It is located on the grounds of the hospital; has a court room in the building and may be justly considered a true psychopathic hospital. It is regarded as the best hospital provision for the insane in the state.

San Francisco has a detention hospital which accommodates from 12 to 18 patients, but it is a place for detention rather than treatment of patients. An after-care physician attends all exami-

nations of alleged insane cases in court and the Lunacy Commission thus becomes cognizant of them and of changes in their condition.

Oakland has a fair detention hospital in a separate building adjoining the Alameda County office building. Neither the San Francisco nor Oakland institution can be regarded as a psychopathic hospital.

Dr. F. W. Hatch states that generally throughout California similar provision is made for the care of the insane who are awaiting commitment. In some counties two or more rooms are provided in the county hospital and in others in the jail building, but apart from the jail proper, so that there may be no association with criminals.

Outside of the Psychopathic Hospital at Los Angeles, insane cases are not usually detained more than 24 hours unless there may be great doubt as to the diagnosis of insanity. A woman nurse or attendant is provided for women in detention and accompanies them if committed to a hospital. There has been much improvement throughout the state in the matter of detention hospitals, but much remains to be done, as there is often difficulty in inducing boards of county supervisors to provide sufficient attendants and nurses to protect and carefully observe all persons brought temporarily to these hospitals. It is also difficult frequently to secure from county sheriffs proper care of the rooms assigned to the insane, more especially those of male patients, as few male attendants are employed. The Lunacy Commission has no well-defined authority over these hospitals, but has the right to inspect and to make recommendations.

In New York, by the provisions of a recent law, the care of insane persons prior to commitment to a state hospital is regarded as one of the proper functions of the health service of the state and made one of the duties of local health officers. In the boroughs of Manhattan and Bronx, however, the duty of properly caring for such persons devolves by law upon the Trustees of Bellevue and Allied Hospitals and in the other boroughs of New York and in the County of Albany upon the Commissioner of Public Charities.

In no case may an insane person be confined in any other place than a state hospital or licensed private institution, nor be com-

mitted as a disorderly person to a prison for criminals. Pending the transfer of an insane person to a public or private institution the proper officers must care for him in a suitable place and provide him with proper medical care and nursing. In Albany County such insane persons are sent to Pavilion F, of the Albany Hospital, the first psychopathic ward to be established in a general hospital. This ward has been in successful operation for the past 12 years and has cared for upwards of 3000 cases of incipient insanity during this period. A fuller description of it will be found among the histories of New York institutions. It is obvious that this method of care is of great service and should be imitated in many other municipal hospitals.

In Minnesota detention hospitals have been established in connection with the state hospitals at St. Peter, Rochester and Fergus Falls, and all insane persons in Minnesota are committed to these institutions provisionally for a period not to exceed six weeks if it is found impracticable to determine the presence or absence of insanity sooner.

In Massachusetts a person who suffers from insanity, mental confusion, except delirium tremens or drunkenness, cannot be placed in a jail or place of detention for criminals, but must be cared for by the Board of Health of the city or town in which he is found prior to commitment to an institution. He may be retained by the superintendent of a hospital for the insane without certificate in an emergency for a period not to exceed seven days.

In Michigan there are no detention hospitals, but a person believed to be insane may be detained for a period of not more than five days.

In Pennsylvania a provision of law exists by which persons suffering from mental disorders may be committed for not more than 30 days to the psychopathic wards of hospitals for observation and treatment, in the same manner as persons are committed to hospitals for the insane. If they are found to be insane they must be regularly committed and removed to a hospital for the insane within 30 days.

In Philadelphia Dr. Woodbury writes:

In the case of indigent patients who are taken up on the street by the police and who are suspected of mental disorder, the custom is to admit them to a psychopathic ward of the Philadelphia Hospital and detain them

there for a period long enough to determine the question of their sanity or insanity. If sane, they are discharged, but if they need medical treatment, they are transferred to another department of the hospital. If insane, they are examined by two physicians appointed for the purpose, who certify to the fact of their insanity and their need of care and treatment in an institution, and they are then transferred to the insane department of the Philadelphia Hospital, or sent to a state hospital. If they have a legal settlement outside of Philadelphia they are reported to the Committee on Lunacy and can be sent to their homes at the expense of the state.

Indigent cases who are not committed by the police authorities may be received in the psychopathic ward in a similar manner on order from physicians appointed by the Health Department of the city.

In cases of private patients their friends may take them immediately to a private hospital or a state hospital where a certain amount of discretion is given to the authorities in receiving them without papers. In cases of emergency an examination by physicians may be made after the patient is already in an institution. Ordinarily, however, such examination and commitment under the Act of 1883, or by court, as the case may be, are made before taking the patient to the hospital.

In Pennsylvania some years since so-called psychopathic wards were authorized in teaching hospitals and provision was made by law for payment by the state of a daily rate of $2 for each patient detained in them. The following account of the Psychopathic Department and State Observation Ward connected with St. Francis Hospital, Pittsburgh, will serve as an example of one of the newest of them:

The present Psychopathic Hospital occupies a four story brick building, located in the rear of the General Hospital and connected with the General Hospital by three corridors. Its capacity is 229 beds. In the basement of the Psychopathic Hospital has been installed a well-equipped and modern hydrotherapy department, in charge of a graduate nurse, who has had special training in hydrotherapy, and of wide experience in hydrotherapeutic treatment of insane patients. Each floor is divided into an excited and quiet ward. Excited and chronic female patients are maintained on the fourth floor; the third floor is devoted to male patients; the second floor to female patients of acute and milder types of psychoses and female alcoholic patients; the first floor contains the male alcoholic ward and the state observation ward established in this hospital a year ago. The largest proportion of the work is with the psychoses of acute onset, and most of the cases are sooner or later transferred to a city, county or state institution. The average stay of a case in the hospital is about three months.

Most of the cases are from among the working and middle classes of people. The Psychopathic Hospital in fact acts practically as a clearing house for city, county and state institutions.

The St. Francis State Observation Ward at Pittsburgh has a male and a female department, each of 12 beds capacity, and seems to be distinct from the Psychopathic Hospital. Only mental cases are accepted in this ward; cases where doubt exists as to mental state and whether or not it is advisable to hold the patient under a regular commitment. Cases are kept against their will 30 days, at the end of which time they are regularly committed to the Psychopathic Hospital, or transferred to city, county or state institution; or, if recovered, they are discharged on parole.

The practice in the District of Columbia is also somewhat similar. Dr. White writes:

> Practically all insane persons apprehended in the District are taken to the Psychopathic Department of the Washington Asylum Hospital. This corresponds to the county hospital in other jurisdictions. Here they are kept indefinitely under the immediate supervision of the District alienist, and those patients who are suffering from acute conditions, such as delirium tremens, from which recovery takes place promptly, are not committed, but those who appear to have well-defined psychoses and which will require some time for treatment are then sent to the Government Hospital by the Commissioners of the District of Columbia under a temporary 30-days' commitment. During this period of 30 days they are cited into court and tried and committed.
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> This practice has grown up without any special justification from a legal standpoint, but it has been the outgrowth of the efforts of two or three physicians to improve things in this jurisdiction. The psychopathic ward at the Washington Asylum Hospital, while it is overcrowded most of the time, and the equipment is very crude, does good work, and a short time ago received a sufficient amount of money to install in the basement a good hydrotherapeutic equipment.

In South Carolina a person may be received upon certificates of insanity from two physicians without an order from the judge of probate for a period not to exceed five days.

A similar provision of law exists also in Tennessee.

In most of the remaining states the jail or the lock-up seems to constitute the only provision which is available for the emergency care of such emergency patients.

The same also is reported to be true of the provinces in the Dominion of Canada.

X.

THE STATE PSYCHOPATHIC HOSPITAL AT THE UNIVERSITY OF MICHIGAN.[1]

The movement which led to the establishment of the State Psychopathic Hospital at the University of Michigan had its source in the increasing interest shown during the period between 1890 and 1895 by institutions for the insane throughout this country in the subject of pathological and scientific work.

Michigan was fortunate in having a system of asylum administration which made it possible for these institutions to have mutual and effective discussions of matters relating to hospital policies. This was established by the Legislature in 1877, when it was provided by statute that "it shall be the duty of the boards of trustees to meet jointly at least twice each year to adjust all questions which may arise pertaining to said institutions." This organization is known as the Joint Board of Trustees of the Hospitals of Michigan.

As early as 1887 we find a discussion in a paper by Dr. George C. Palmer, superintendent of the Michigan Asylum at Kalamazoo, of pathological and scientific work in the Michigan asylums. In this was expressed a dissatisfaction with existing conditions, and the proposal was made that the institutions should cooperate in their pathological work and have one pathologist, who should serve all of the state asylums. The recommendations of this paper were referred to a committee, which reported at the meeting a year later, in 1888. The committee recommended "that an assistant physician shall be appointed and designated to do microscopic and pathological work for the three asylums of Michigan in common, and that each one of these asylums shall defray one-third of his salary and expenses and shall have a right to his services." For some unexplained reason these recommendations were laid upon the table and there was no further discussion regarding centralization of laboratory work until ten years later, when, at a meeting of the joint

[1] Furnished by Dr. Albert M. Barrett, director and pathologist of the Michigan state hospitals.

board, this subject was brought up for discussion in a paper by Dr. Wm. M. Edwards, superintendent of the asylum at Kalamazoo. In this a plan was proposed for establishing an affiliation of the state asylums for the insane with the University of Michigan in systematically conducted pathological work, which would be to the mutual advantage of both. This suggestion had already received the informal approval of the university. The recommendations were referred to a committee, consisting of the medical superintendents of the several asylums, to report at the next meeting.

It is quite probable that the renewed interest of the Michigan asylums in this subject was stimulated by the consideration which had in recent years been given to centralization of pathological work by the New York Commission in Lunacy, which resulted in the organization of the Pathological Institute of the state hospitals in New York City in 1895. In this same period important advances in the development of clinical and laboratory work in hospitals for the insane had occurred at Kankakee, Ill., in the changes in its work following the selection of Dr. Adolf Meyer as pathologist; at McLean Hospital, in the organization of its new laboratories under Dr. August Hoch in 1895, and in the same year the reorganization of the laboratories at Danvers under Dr. William L. Worcester. Probably these events had an influence upon the committee then considering the recommendations for an affiliation with the university. As a result of conferences with a committee from the university, consisting of Dean Victor Vaughan and Regent Dr. Herman Keefer, the proposition was made at the meeting in November, 1897, "that each Board of Trustees shall appropriate from its funds the sum of $125 for pathological work for a period of one year; this sum to be paid as a salary to a competent pathologist to be recommended by the university authorities and approved by the Board of Trustees; this pathologist to reside in Ann Arbor and to give his whole time to asylum pathological work under the direction of the professor of pathology at the university."

These recommendations were adopted, and the further arrangements were left to a committee composed of the medical superintendents. This committee, acting with one from the university, appointed Dr. Theophil Klingman, who was connected with the department of nervous diseases at the university, to serve as pathologist for the asylums of Michigan for one year beginning

January 1, 1898. Each institution was to contribute equally towards his salary.

The plan followed during the first year of this arrangement was largely experimental. No definite policy seems to have determined the work. Visits were made by the pathologist to the various institutions and whatever laboratory work was undertaken was done at the university, with material sent from the asylums. At the next meeting of the Joint Board of Trustees in November, 1898, the committee in charge of the pathological work was able to propose the following plan: "1. That each asylum or hospital pursue some work in general pathology. 2. That each asylum or hospital have one member of its staff experienced in this line of work and given time for accomplishing scientific investigation in general and special pathology. 3. That the character of the work done be determined upon by the pathologist and members of the medical staff of each institution. It was recommended that when practicable the instruction be given at the Michigan Asylum at Kalamazoo by the pathologist. 4. That an annual report be printed in addition to the biennial report, embodying the medical, surgical, clinical, pathological or psychological work." These recommendations were adopted with the exception of that relating to the publication of a report.

The relation of the asylums to the university was made still more intimate in 1898 by the appointment of the superintendents of the state asylums as special lecturers in the department of medicine of the university. For many years it had been the custom for medical students at the university to obtain much of their instruction in mental diseases from visits to one of the state asylums. Dr. Wm. J. Herdman, for many years professor of mental and nervous diseases at the university, was in charge of these visits.

The plan which had been adopted did not seem to be completely satisfactory to the several asylums; yet at the time any better arrangements did not seem possible. In a paper by Dr. E. A. Christian, presented to the Joint Board in 1900, it was mentioned "that the plan in Michigan may be conceded to be original and unique; it may accomplish results at a minimum of cost without detracting from authoritative standing." It was decided to continue the existing arrangement for another year. At this phase of

the situation in Michigan the idea of a special psychiatric hospital, with laboratories in which might be centralized the pathological work of the state asylums, began to assume shape. Quite independently of the movement for centralized laboratory work carried on by the asylums, Dr. Wm. J. Herdman developed a plan for the organization of a special division of the University Hospital which should be devoted to the care of mental diseases. At about this time the Albany General Hospital opened a special division for mental disorders, and this probably had an influence in directing the movement then showing itself in Michigan. We find reference to this in a paper by Dr. Christian presented before the Joint Board of Trustees in January, 1901, on "The Movement Towards Psychiatric Hospitals and Psychiatric Clinics." In this paper, entirely unaware of the movement in which Dr. Herdman was interested, he remarked with much foresight: "I believe it will be only a question of time before the movement for the psychiatric hospital will make its appearance in Michigan. It is a matter of indifferent concern whether the movement is in connection with a private or semi-public corporation in a large city or with the university."

It was during the discussion following this paper that the Joint Board of Trustees became aware of the progress Dr. Herdman had made in his efforts to develop a psychopathic ward in connection with the university and that at this very time a bill had been drafted to secure from the Legislature, then in session, the facilities to carry out this plan. This measure was entirely the creation of Dr. Herdman. It was due to the personal efforts of Dr. Herdman that the measure became enacted into a law and that the psychopathic ward was established.

By this act, under date of May 25, 1901, there was appropriated $50,000 for the construction and equipment of a psychopathic ward of 40 beds upon the hospital grounds of the University of Michigan. It was to be an additional ward of the present University Hospital and under its management, but the superintendents of the several state asylums were to be members of its clinical staff. Its business administration was to be under the superintendent of the University Hospital, but its medical supervision was to be under the head of the department of nervous and mental diseases of the university.

Patients were to be sent to this ward, if the judge of probate, during the hearing of an application for commitment to an asylum, should be convinced from the report of three examining physicians that "there were present in the condition of the patient such factors as would render detention in a suitable psychopathic hospital for a brief period advisable as a precautionary or curative measure; or if the case required the services of specialists trained in the treatment of disorders other than those of the nervous system." If the patient recovered he would be discharged; if not, he could be transferred to one of the asylums in the state. It was also to be possible for the superintendents of any of the asylums to transfer to it any of their patients who might be benefited by the facilities for treatment which the general hospital of the university possessed.

As the University of Michigan maintains a department of homeopathy the relatives or friends of a patient were free to choose the school which should take charge of the treatment, provided this did not conflict with the general rules of the regents of the university, for the administration of the ward.

The cost of the maintenance of the patient was to be paid by the county in which the patient resided if he were a public charge, and if he were to be privately supported, such rates were to be paid as the regents of the university should determine.

There was no mention in the act of any provision for laboratory or research work, or of any co-operation with the asylums other than in the transferring of patients and affiliation of the hospital superintendents with the staff of the ward in the treatment of patients. While there is no specific mention as to the use of patients in teaching, it is certain that the existing rules of the University Hospital, which provided for the use of any patient of the hospital for clinical teaching, also applied to the new ward.

It was in some ways unfortunate for the immediate success of the new organization that the co-operation of the asylum officials of the state had not been invited in framing the provisions of the act, especially when the asylums were trying to arrange for a mutual co-operation in laboratory work. Undoubtedly this circumstance hindered the efforts of the university authorities in getting the new organization under way. In turn the situation created by the establishment of the psychopathic ward presented

to the asylums possibilities of solving their difficulties as to the centralization of laboratory work, which compelled consideration in any further plans they might undertake.

Not until a year after the passage of the act establishing the psychopathic ward was there any mention at the Joint Board meetings of the new organization. The asylums were still co-operating in the arrangements for pathological work made in 1898, but there was a general feeling among them that it was far from satisfactory. The idea was still strong that the work of the institutions could best be done in a central laboratory at one of the institutions, or in a large city like Detroit, or in connection with the university.

A careful consideration of the provisions of the act establishing the psychopathic ward made it evident that there were many difficulties to prevent the new organization from working smoothly under the laws relating to the insane and in its relation to the asylum system of the state. The best way to remedy this was to secure the co-operation of the asylums in its administration; and efforts, both from the side of the asylums and from the university, were active to this end. In July, 1902, a committee of trustees and superintendents of the asylums recommended that an affiliation be entered into with the proper department of the university at Ann Arbor for the study of pathology and for clinical research in mental diseases, and that this department be known as the Department of Pathology and Clinical Research of the Michigan Asylums and Psychopathic Hospital; that the central laboratory be located at the Psychopathic Hospital with branches at the several asylums; that there be employed an experienced investigator of more than local reputation who may be agreed upon by representatives of the asylums and university in conference; that the amount of salary and method of payment and all matters of expenditures and the details of the plan for affiliation be arranged by the conference committee. All arrangements were to be subject to the approval of the Joint Board of Trustees. These recommendations were adopted and further arrangements were left to a committee composed of the superintendents of the asylums. On this committee were Dr. J. D. Munson, superintendent of the Northern Michigan Asylum at Traverse City; Dr. E. A. Christian, superintendent of the Eastern Michigan Asylum at Pontiac; Dr. W. A. Stone, acting superintendent of the Michigan Asylum at Kalamazoo, and Dr. G.

L. Chamberlain, superintendent of the Upper Peninsula Hospital at Newberry.

The establishment of the psychopathic ward opened to the university an entirely new field of work; and it could hardly be expected that it should at first know definitely how to enter upon it. This fact made it difficult for the committee of the asylums to conclude any arrangements which were mutually satisfactory. The act establishing the psychopathic ward had no provision for the appointment of a pathologist such as the asylums were seeking, nor was there any provision for the maintenance of laboratory work should a mutual arrangement be possible. Further conferences between the committees made it possible to present to the Joint Board of Trustees in July, 1903, the following propositions:

1. That a laboratory for clinical and research work in insanity shall be maintained in connection with the psychopathic ward.

2. That it be under the charge of an experienced investigator; his salary to be paid by the asylums; his official title to be Associate Professor of Neural Pathology and Pathologist of the State Asylums and Director of the Asylums' Laboratories.

3. The duties of the pathologist shall be to conduct clinical, pathological and research work in mental diseases in the Psychopathic Hospital at Ann Arbor and in the state asylums of Michigan.

4. The asylums are privileged to send members of their staff to the central laboratory for clinical and research work.

5. It was to be possible for any state asylum to transfer cases to the Psychopathic Hospital for special study.

6. The university should annually allow for the support of the laboratory a sum of money at least equal to the salary of the director.

7. The director of the laboratory was to report to each asylum the work accomplished during the year and all work was to be reported as from the Michigan asylums' laboratory.

These propositions did not meet the approval of the Joint Board of Trustees and again a plan for affiliation with the university came to naught.

There was no inclination on the part of the asylum officials to obstruct the progress of the development of the psychopathic ward, but rather the wish was general to affiliate their pathological work with the new organization at the university. It was, however, felt by many that there was no legal right on the part of the asylums to direct any of their funds towards the maintenance of an institution so directly a part of the university. As no further

progress towards the affiliation seemed possible because of these legal objections, the Joint Board postponed indefinitely further consideration of the matter.

The subject was taken up a year later, when Dr. Herdman was invited to address the Joint Board on the situation which had developed in view of the failure of the asylums to co-operate in the new ward, the building of which at this time was nearing completion. As it seemed feasible to adjust any legal obstacles by legislative enactments, this address secured renewed interest on the part of the asylums towards the support of the organization at Ann Arbor, and a committee was appointed from the Joint Board to arrange for the completion of the building, the appointment of a medical director, and the opening of the ward for the reception of patients. A few months later the Legislature provided for the organization and maintenance of a laboratory in connection with the psychopathic ward and for the administration of the ward jointly by the Board of Regents and the Joint Board of Trustees of the Michigan Asylums. They were to appoint "an experienced investigator in clinical psychiatry, who shall be placed in charge of the psychopathic ward, whose duty it shall be to conduct the clinical and pathological investigations therein; to direct the treatment of such patients as are inmates of the psychopathic ward; to guide and direct the work of clinical and pathological research in the several asylums of the state, and to instruct the students of the State University in diseases of the mind." His official title was Pathologist of the State Asylums.

By these provisions the university secured the helpful cooperation of the state hospitals for the insane, and the institutions for the insane acquired a practical plan for a centralized direction of their scientific work.

A joint committee from the Board of Regents of the university and from the Joint Board of Trustees of the State Hospitals at once took up the administration of the new organization, and in September of 1906 they appointed as director of the psychopathic ward Dr. Albert M. Barrett, at that time pathologist of the Danvers (Massachusetts) Hospital for the Insane and assistant in neuralpathology in the Harvard University Medical School. The building was completed early in 1906 and on February 7, 1906, it received its first patients.

It became apparent during the first year's experience in the administration of the new institution that there were many difficulties which had not been foreseen in drafting the statutes for its management, and that unless these were revised the smooth working of the psychopathic ward as a part of the state organization for the care of the insane was by no means assured.

Its problems were quite different from those of the General Hospital of the university of which it was a part. It seemed best to secure for the institution somewhat more independence in its organization and administration, but not to lessen its intimate relation with the teaching organization of the medical department.

These conditions made it advisable to enact new statutory provisions for the organization and administration of the psychopathic ward, which was done by the Legislature of 1907. The name of the institution was changed to "The State Psychopathic Hospital at the University of Michigan." Its relations to the teaching facilities of the university remained unchanged, but its administration was placed in charge of a Board of Trustees, which was to be composed of four members from the Board of Regents of the university and four chosen from the Joint Board of Hospital Trustees. The board was given the authority vested by statutes in the Boards of Trustees of the State Hospitals for the Insane.

Its purposes were distinctly defined as a "state hospital, specially equipped and administered for the care, observation and treatment of insanity and for persons who are afflicted mentally, but are not insane."

The medical director of the hospital by virtue of such position was pathologist of the state hospitals for the insane and with the approval of the Board of Regents was professor of psychiatry in the department of medicine and surgery in the State University, to give instruction to the students in diseases of the mind.

A further provision of the act was that "there shall be maintained as a part of the Psychopathic Hospital at the University of Michigan a clinical pathological laboratory, which shall be a central laboratory for the Michigan state hospitals for the insane and a laboratory in which research into the phenomena and pathology of mental diseases shall be carried on." For the maintenance of the laboratory and for the payment of the official salaries of the hospital an annual appropriation was made available.

Within a few months a systematic course of clinical instruction in psychiatry was organized and for the first time an American university medical school was provided with a clinic which made it possible to give adequate instruction in this branch of medicine.

A supervisory administration was at once organized in connection with the scientific work of the several state hospitals, which has since been maintained with earnest co-operation between all of the state institutions caring for the insane.

XI.

THE BOSTON PSYCHOPATHIC HOSPITAL.[1]

The most advanced institutions that deal directly with the problems of psychiatry in their medical, social and scientific aspects are known as psychiatric clinics and psychopathic hospitals. The idea of the psychiatric clinic appears to be a little older and narrower than that of the psychopathic hospital. Traces of the idea of a psychiatric clinic are found early in the literature of German-speaking countries; but the completed idea was sketched in 1868 by Griesinger, one of the few men of commanding intellects that psychiatry has enjoyed. The idea of a psychiatric clinic is a university idea, and the current of influence runs from instruction and research of a more or less academic nature to the practical problems of the insane.

The term *psychopathic hospital* appears to be one of American coinage; at least Dannemann, in his account of the *Stadtasyl* of the German system, so states. At all events, the idea of the psychopathic hospital is broader than that of the psychiatric clinic, and the current of influence which dominates it is likely to be from the practical interests of the patients backward upon the university medical school. Practically all the newer movements in mental hygiene have come from practical alienists rather than from university workers in America. In fact, those who are busy with the details of the propaganda for the establishment of psychopathic hospitals in the United States of America are troubled by the apathy of universities and medical schools in connection not only with psychiatry, but with all other disciplines having relation to the nervous system, taken as a whole. One influence, however, of an important nature has been derived from American universities. The great frequency and comparatively well-endowed condition of departments of psychology in our country are responsible for improvements in mental hygiene, whether in the direction of helping the individual, helping officials in their tasks or improving

[1] This chapter has been furnished by E. E. Southard, M. D., director, Psychopathic Hospital; pathologist, Massachusetts State Board of Insanity; and Bullard professor of neuropathology, Harvard Medical School.

society in general. Massachusetts in especial has enjoyed the quite different stimuli of Professors William James and G. Stanley Hall, of Harvard and Clark Universities, respectively.

Those who recall the early development in Massachusetts of the conception of a psychopathic hospital must remember many names. Pliny Earle in particular, in his address at the laying of the corner-stone of the General Hospital for the Insane of the State of Connecticut, as long ago as 1867, speaks as follows:

> Carbon agglomerated is charcoal. Carbon crystallized is diamond. What charcoal is to the diamond, such, I believe, is the psychopathic hospital of the present compared with the psychopathic hospital of the future. . . . . When the defects which I have mentioned shall have been thoroughly remedied by a comprehensive curriculum, a complete organization, a perfect systematization, an efficient administration, the charcoal now just ready to begin the process of crystallization will have become the diamond and the world will possess the psychopathic hospital of the future.

The late Dr. George F. Jelly, medical examiner for the City of Boston, for years laid emphasis upon the desirability of such a hospital. It took, however, 12 years from Dr. Owen Copp's report as executive officer of the State Board of Insanity in 1902 before the Psychopathic Hospital in Boston became a fact. In the year 1915 the Psychopathic Hospital in Boston has already passed through its wards more than 5000 different patients, the majority of whom have been cases of dubious nature; that is to say, cases that could not properly be adjudged insane forthwith by probate courts.

The hospital has proved an extensive success in Massachusetts, and few of the practitioners who employ its devices but wonder how the metropolitan district and the state at large ever got on without these advantages. It must be stated emphatically, however, that the value of a psychopathic hospital, viz., a hospital that deals not merely with pronounced insane persons (the "probate court" group), but predominently with the psychopathic "not-insane," the psychopathic "not-yet-insane," the early and incipient cases of mental diseases, and a score of types of mild and doubtful psychopathy lying at the base of a certain number of juvenile, adolescent and adult delinquencies, is a value which greatly depends upon a proper basis in statutory law. So far as I know at the present time, only the Commonwealth of Massachusetts and the municipality of New York possess laws permitting wide usage

of a system by which cases can be brought with the greatest facility for temporary care out of the community. New York has gone a step farther than Massachusetts in this regard, since New York officials are enabled to send an ambulance after cases requiring temporary care. But a state should be provided not only with laws permitting facile disposition of the "temporary-care" group, but with proper laws for the admission of voluntary patients. A proper law for the admission of voluntary patients permits the state to draw upon its treasury for the care of *indigent voluntary cases.* The importance of this provision for the indigent voluntaries is mentioned because in a large number of states with voluntary admissions the state laws do not inure to the benefit of any large number of cases.

The Psychopathic Hospital has been able to use to the utmost the provisions of its "temporary-care" and voluntary-admission laws. More than 1000 temporary-care cases are brought into the hospital yearly and from 400 to 500 voluntary cases arrive, to say nothing of great numbers of out-patients. At present our census of out-patients amounts to about 1500 a year. Who could have supposed some years since that patients would come in such numbers to a clinic for mental cases and for mental cases only? An important feature of the out-patient group, from the standpoint of mental hygiene, is that, aside from the after-care group of cases referred to the out-patient department (about one-fifth of our out-patient census), only about one-quarter of the remainder are recommended for institutional care. In short, the dispensary feature of the psychopathic hospital does not act like a vacuum to draw into the state's institutions all of its patients.

So much of detailed description is necessary to show what sort of institution the founders of the Psychopathic Hospital proposed to establish in their propaganda with the public, the Legislature and the executive chamber.

The propaganda was in fact almost entirely non-political; and with the issue of a variety of reports by the State Board of Insanity, beginning with the year 1902, it proceeded slowly but surely until eventually one of the thriftiest executives of Massachusetts, the late Governor Eben S. Draper, found himself entirely willing to support the establishment of a hospital which was to be central in location; to cost in the neighborhood of $600,000; to

contain upwards of 100 beds, and to operate at an expense of more than $100,000 a year. It is worth while to reproduce at this point the functions of the Psychopathic Hospital as they were described in the State Board's annual report for 1910:

The Psychopathic Hospital should receive all classes of mental patients for first care, examination and observation, and provide short, intensive treatment of incipient, acute and curable insanity. Its capacity should be small, not exceeding such requirement.

An adequate staff of physicians, investigators and trained workers in every department should maintain as high a standard of efficiency as that of the best general and special hospitals, or that in any field of medical science.

Ample facilities should be available for the treatment of mental and nervous conditions, the clinical study of patients on the wards, and scientific investigation in well-equipped laboratories, with a view to prevention and cure of mental disease and addition to the knowledge of insanity and associated problems.

Clinical instruction should be given to medical students, the future family physicians, who would thus be taught to recognize and treat mental disease in its earliest stages, when curative measures avail most. Such a hospital, therefore, should be accessible to medical schools, other hospitals, clinics and laboratories.

It should be a center of education and training of physicians, nurses, investigators and special workers in this and allied fields of work.

Its out-patient department should afford free consultation to the poor, and such advice and medical treatment as would, with the aid of district nursing, promote the home care of mental patients. Its social workers should facilitate early discharge and after-care of patients, and investigate their previous history, habits, home and working conditions and environment, heredity and other causes of insanity, and endeavor to apply corrective and preventive measures.

The success of the propaganda for the Psychopathic Hospital was achieved with the aid of numerous alienists and neurologists of Massachusetts, supported by the interest which members of the committees of the Legislature and of successive Governors took in the matter. I should mention, in addition to Dr. Jelly, above named, in the first place Dr. Owen Copp, without whose vision doubtless the Psychopathic Hospital would not now exist. Dr. Copp was supported in his efforts by the members of the State Board of Insanity and of their chairman, Dr. Herbert B. Howard. Among others I should mention Dr. Walter Channing, whose quiet persuasiveness has often been of avail with legislative committees and who was chairman of the trustees of Boston State Hospital at the time of the establishment of the Psychopathic Hospital as a

department thereof. Committees of the Boston Society of Psychiatry and Neurology exhibited much activity. Dr. L. Vernon Briggs was able by his energy and resourcefulness to influence legislative committees and other persons in such wise as to push forward the establishment of the temporary-care provisions and the hastening of provision for the Psychopathic Hospital type of case.

Since the opening of the hospital its work has been aided by the trustees of the Boston State Hospital and by the State Board of Insanity throughout the changes which have occurred in their membership. The members of the present Board of Insanity have been able to develop the pathological service of the State Board in such wise as to help the research function of the Psychopathic Hospital to a surprising degree.

The present Board of Trustees of the Boston State Hospital has been especially interested in improvements in administration of the hospital which had been at first attempted with too small a force, and the efforts of its chairman, President Henry Lefavour, have been untiring in this direction.

I will not consider the statistical feature of the hospital in detail, but will present a table showing the tremendous stimulation which voluntary admissions have received. My table takes up voluntary admissions to all public institutions of Massachusetts from the year 1895 to 1913 inclusive. Practically the entire increase shown by the figures for the year 1913 is due to the Psychopathic Hospital.

VOLUNTARY ADMISSIONS TO PUBLIC INSTITUTIONS OF MASSACHUSETTS.[1]

Year.	No. of Admissions.
1895-1899 (5 years)	405
1900-1904 (5 years)	520
1905	84
1906	125
1907	156
1908	195
1909	185
1910	200
1911	237
1912	282
1913	636

[1] Including a large private institution, McLean Hospital.

XII.

RESEARCH WORK IN HOSPITALS.

As has been already indicated, the earlier and most pressing work of those who were engaged in the care of the insane was not so much to enlarge the boundaries of their knowledge of the underlying causes of insanity as to provide shelter and care for persons who, unless they secured it, were exposed to serious hardships, woful privations and permanent mental disability. It is therefore not at all strange that special attention at first could not be given to the pathology of insanity or to the study of morbid cerebral anatomy.

In 1846 and 1847 three papers on the pathology of insanity appeared in Volumes II and III of the *American Journal of Insanity* from the pen of Dr. Pliny Earle, who was then in charge of the Bloomingdale Asylum, a branch of the New York Hospital. In these papers Earle gave excellent clinical histories of several cases of insanity which had come to autopsy, with detailed descriptions of gross pathological appearances of organs and tissues thus obtained. An account was also given of changed vascular conditions in the brain and an attempt was made to explain them. The papers seem to be fully abreast with the pathological knowledge of that date, which was necessarily largely descriptive in character because of the imperfection of apparatus for microscopic study and the lack of proper lenses and staining reagents.

The next papers of any special value as recorded in the meetings of the Association and published in the *American Journal of Insanity* were presented by the late Dr. Joseph Workman, of Canada, upon the morbid anatomy of general paresis. Although the study was a step in the right direction, the results were of no great value and could not have been expected to be, in the existing state of knowledge. It must be borne in mind too that general medical pathology as we now know it did not exist and that research workers in every branch of medicine were groping in a similar inefficient manner. They knew little or nothing of microscopical study, and as to pathology were contented to describe gross appearances without knowledge of structure, as did Bright and Carswell a half century before.

The first systematic effort in the United States in connection with an institution to study the underlying bodily conditions in insanity was initiated by the late Dr. John P. Gray, of Utica, who, although not a student of pathology, had large conceptions and broad ideas of its importance. He made a report to the managers of the Utica State Hospital in 1868 which induced them to authorize the temporary appointment of Dr. E. R. Hun as pathologist at Utica. In the following year the managers presented in their annual report an appeal to the General Assembly for an appropriation to maintain a pathological department. It is interesting to observe the tentative character of the plan and the wisdom of it. Up to this time little study had been made of any symptoms in the insane beyond deviations from normal conduct, and the plan very judiciously set forth the importance of studying the accompanying bodily derangements of insanity. It was proposed to study bodily secretions and excretions, the state of the pulse as revealed by the sphygmograph, the effect of remedies upon the pulse, the condition of the cerebral vessels as revealed by the ophthalmoscope, the condition of the skin, the morbid conditions developed at autopsy, and to portray them by photographs and photomicography. The plan as presented may seem haphazard and fragmentary, but such also was the condition of all attempts at investigation during the barren epoch in the history of medicine prior to 1880. The causes of disease seemed wholly mysterious and were sought " in the heavens above and in the earth beneath " far more frequently than in the human body. Edward R. Hun, a young physician and a resident of Albany, but educated abroad, was accordingly appointed in 1868 and the fruits of his labors may be traced in the annual reports of the Utica State Asylum and in the *American Journal of Insanity*, which was at that time edited and published at Utica. He seems to have been industrious and painstaking, and, while his researches were not epoch-making, they served the useful purpose of keeping the importance of the study before the medical profession. He held the position until 1873, when he resigned to enter upon medical practice and teaching at Albany. He wrote upon the " Pulse of the Insane " and upon " Hæmatoma Auris."

The position of pathologist was later filled by Theodore Deecke, of Utica, who was a technician rather than a pathologist.

He was a good photographer and microscopist and became more interested in the photomicography of brain sections than in the study of disease. He could make sections, but could not interpret them. The sphygmographic and therapeutic studies which had been inaugurated by Hun soon fell into the hands of members of the regular medical staff and Andrews, Kempster and Kitchen gave several excellent papers as the result of them in the *Journal of Insanity*. Dr. John P. Gray, on the other hand, became much interested in gross and microscopic pathology and gave a stereopticon demonstration of his results before the Association at the Auburn meeting in 1878. Kitchen failed in health, and resigned; Kempster received an appointment at Oshkosh and Andrews at Buffalo and all ceased to do pathological work.

Deecke soon became interested in lines of commercial work which were not closely associated with pathology and for a number of years little productive work was done. Dr. Gray failed in health and upon his death in 1886 the pathological work was practically discontinued.

The initiative of Utica, however, had been of great value to the institutions of the country, and however disappointing the result, it is evident that it had demonstrated the need of more specialized effort. This came about a few years later when, under the lead of Dr. Carlos F. MacDonald, at that time president of the New York Lunacy Commission, the New York State Pathological Institute was established in New York and Dr. Ira Van Gieson was appointed director. Then for the first time in New York an attempt was made to study the pathology of insanity in a systematic and orderly manner. The Pathological Institute became a clearing house for the study of morbid specimens sent to it from the different state hospitals and the plan was inaugurated of giving instruction to men from these hospitals, who came for definite periods of instruction. Dr. Van Gieson, although possessing great knowledge and unusual ability, was not fitted by temperament or experience to fill the position of director of so large a work, and in 1902 he resigned and Dr. Adolf Meyer was made director.

The State Pathological Institute, which had occupied expensive, not to say extravagant, quarters in New York City, was later transferred to Ward's Island and began its true work of research and education. The training of members of the staff of state

hospitals in history-writing and case-taking, in the study of mental disease and in normal and pathological brain structure was begun with the effect to improve the medical work in every state hospital. Too much cannot be said in praise of the work then initiated, which has increased in efficiency each year up to the present writing.

Upon the resignation of Dr. Meyer in 1910, to accept the position of director of the Phipps Psychiatric Institute in Baltimore, Dr. August Hoch, former pathologist at the McLean Hospital, succeeded him and continued the work.

Meantime in Massachusetts at McLean Hospital, under the leadership of Dr. Edward Cowles, an attempt had been made to connect the investigation of mental disease with the growing sciences of psychology and neurology on one side, and with the study of physiological fatigue and the relations of mental disorders to bodily metabolism.

The first work of Dr. W. A. Noyes in 1889 related largely to psychology and neurology, and upon his resignation in 1892, Dr. August Hoch, his successor, attacked problems of a physiological character, involved in the effect of stimulants upon fatigue and of the action of remedies, and added to them studies and investigations as to Kraepelin's methods. It soon became evident that an expert chemist was required for the study of metabolic changes and Dr. Otto Folin was added to the staff and made valuable contributions to methods of study. Later, when he resigned to take up work in connection with Harvard University, he was succeeded by Dr. S. I. Franz, who had received a special training in physiology and was an expert in physiological investigation. Upon his resignation, to go to Washington, he was succeeded by Frederick Lyman Wells in psychology and by Dr. F. H. Packard and later by Dr. E. Stanley Abbott in pathology.

The work accomplished at McLean has been of a high character and of wide-reaching importance.

Meantime the initiative of McLean had borne fruit in several state institutions, notably at Worcester and Danvers. At the former Dr. Adolf Meyer was appointed pathologist in 1896 and gave valuable assistance in reorganizing the medical work and perfecting methods of pathological investigation.

Upon his transfer to the New York State Psychiatric Institute in 1902 the special work of a pathologist was assumed by the pathologist of the State Board of Insanity.

A similar work was undertaken at Danvers by Dr. W. L. Worcester and continued after his death by Dr. A. M. Barrett, but upon the transfer of the latter to the State Psychopathic Hospital at Ann Arbor the work was taken over by Dr. E. E. Southard, who was later made State Pathologist.

Useful pathological work has also been done by Dr. S. C. Fuller in connection with the Westborough State Hospital. Valuable pathological investigations have also been made in other states, notably in Rhode Island by Drs. William McDonald and Farnell; in Indiana under Drs. Edenharter and Potter; in Illinois under Drs. Adolf Meyer, Stearns, Podstata, Singer and others; in Ohio at Massillon under O'Brien; in New Jersey under Drs. Cotton, Prout, Hammond and others; at the Government Hospital at Washington under Drs. Blackburn and Franz; in Pennsylvania by Drs. Mitchell and Orton; and in New York quite generally in all the state hospitals, so that the outlook for future fruitful pathological investigations seems bright.

CHAPTER VII

TRAINING OF NURSES AND ATTENDANTS

I.

TRAINING SCHOOLS FOR NURSES AND THE FIRST SCHOOL IN McLEAN HOSPITAL.[1]

The history of nursing in hospitals for mental diseases in the United States had its beginning in its first asylums. In these were adopted the principles of the great reform in the care of the insane begun contemporaneously by Pinel and Tuke. But while the principles of humane care were making slow progress in the long established institutions of the older countries, their general adoption in all the new asylums in America gave that country the leadership for a number of years in the reform which included the practice of the principles of intelligent and sympathetic attendance upon the insane. It is of great interest and importance to note here the earlier events in this great general reform in the care of the insane, for in them we find the origins and the conditions out of which came the special reform of nursing.

The influence of the teachings of Pinel and Tuke wrought profound changes and became prevalent by the end of the first half of the nineteenth century. In Europe the work of Esquirol sustained that of Pinel; Jacobi visited the Retreat at York, and his writings reflect most largely the spirit of the English reform; Fliedner was a neighbor of Jacobi, at only twelve miles distance, whose work had been going on eleven years, when Fliedner included in his purpose the care of the insane, and re-established the nursing sisterhoods in the Protestant church following the historic example of the Catholic orders. The later expression of the beginnings at the York Retreat was given by the work and writings of Samuel Tuke, who republished those of Jacobi, and Charlesworth, Hill and Connolly.

In the United States, the examples of the older countries having been adopted, the prevalence of the reform was general

[1] By Edward Cowles, M. D., formerly superintendent of McLean Hospital.

and earlier. By the end of the second decade Rush had written in the most humane spirit; the institution at Williamsburg, in Virginia, another in connection with the New York Hospital, and the Frankford Asylum, as an offshoot of the York Retreat, had been established; as also the McLean Asylum, where Wyman put in practice the modern spirit of humane attendance. At the latter place, in the notable fourth decade, contemporary with Jacobi and Fliedner in Germany, Bell published his "Directions for Attendants," and Woodward, at the Worcester Asylum, a similar treatise. This was prior to the publication in England of the "Teachings for Attendants," by Connolly, whose contemporaries within the next ten years in the United States—Kirkbride, Curwen, Ray and others—had great influence by their work and writings in advancing the humane care of the insane in the considerable number of asylums which by that time had been built throughout the country.

This brief reference to the history of the great movement in the first half of the last century, with little more than a recital of notable names familiar to every modern alienist, is sufficient to indicate the intensity of interest and greatness of effort, in which many joined to reform the care of the insane. In Prussia, England and America there was early recognition of the prime need of persons of intelligence and goodness of character who could be interested in the nursing of the insane. In all these countries there were throughout the half century many attempts to establish a system of training such nurses, but little was accomplished beyond the improvement of the individual excellence of the ordinary attendant. Yet, notwithstanding the failure to devise methods of systematic training, it is plain that the leadership in the recognition of the essential requirements of the nursing of the sick and the insane, and the efforts to supply the need, belonged to the alienists. There was no such effort in the general hospitals until the teaching of Florence Nightingale created the great epoch of reform in them. But, although the leadership in nursing-reform passed over to the general hospitals, it was no doubt inspired in part by the example of the work among the insane which was well known when Florence Nightingale went to visit Pastor Fliedner at Kaiserswerth in 1849.

The first thirty years of the last half century, coming down to 1880, witnessed the development of Florence Nightingale's reform; it came to the United States from England in the years 1866 to 1873, soon after the founding of the first training school at St. Thomas' hospital in 1860. The improvement in the care of the insane in the asylums and hospitals had taken the lead in the latter country, but in both the success of the training of women for general nursing had a stimulating influence to new efforts by the alienists.

The spirit of the time was well expressed in the report for 1859 of the Commissioners of Lunacy in England, in which the important question of nursing and attendants for the insane was made a special subject for comment and inquiry as "one to which for many years they had steadily directed their attention"; and they endeavored to "impress upon all who are responsible for the care and treatment of the insane the paramount duty of adopting means for securing the services of competent attendants." When the commissioners reissued, in 1879, their former circular letter, it was declared that "although the care and treatment of the insane have, in most respects, altered greatly for the better, improvement in the character and position of attendants has not been nearly so marked." It was early in this period of thirty years that Browne, at the Crichton Institute, made historic the well-known event of "the first attempt to educate the attendants upon the insane" by a course of thirty lectures in 1854, the very year of Florence Nightingale's going to the Crimea; it was near the end of this period, in 1876, that Clouston read, before the British Medico-Psychological Association, his notable paper in which he lamented the unattainableness of the ideal asylum attendants, and made the significant comment that we cannot "expect to get persons to act as attendants from the (so-called) higher motives" in the absence of inducements to worthy persons to engage in the delicate duties of nursing. Noting also the inequality and the common absence of the necessary instruction, he asked, "Can we not devise and elaborate a systematic professional training for attendants in all our large asylums?" It is noteworthy that thoughtful alienists had long recognized the inadequacy of the higher motives alone to attract worthy persons to this service; Jacobi and Samuel Tuke believed that a sufficient supply of such

persons could not be procured. Thus it was that the alienists were for a long time the first to know what was wanted for good attendants upon the sick and the insane, but, as late as 1880, they had not learned the secret of Florence Nightingale's success.

Before passing from this formative period of modern nursing-reform, it should be noted that one of the first effects upon the alienists was to attract attention to the employment of women in men's wards. In England married women were used as "bed-makers"; in Scotland Batty Tuke had "lady-companions" for his patients of the private class, and Clouston successfully established infirmary wards in charge of women nurses. Yet, in 1880 there did not exist anywhere in the world, outside of the religious orders, a definitely and permanently organized school for the systematic professional training of nurses for the insane. There had been many attempts, especially during the previous ten years; they were generally a few lectures, given by a medical superintendent, or sometimes an assistant medical officer of an institution; or a course of lectures might be once or twice repeated in successive years, and then cease wholly because of the departure of the single person upon whom the instruction depended, or through his failing zeal due to the frequent changes among the attendants and the absence of any apparent improvement in the service. It came to be said that there was no proper place or material for the training of nurses in the general wards of a hospital for the insane. Many believed it would be impossible to get young women, of the class who sought the general hospital schools, to become interested in work with the insane; also that, if a system of instruction could be made successful, the nurses would then leave the service, and the increased labor of medical officers in teaching would be wasted.

In the United States, in 1880, the conditions with respect to the problem of nursing for the insane had come to be much the same as in the mother country under the influence of the great reform in the general hospitals. It is necessary to review these prior conditions in order to trace their formative influence in the next event in this history, which was the permanent establishment of a training school for nurses at the McLean Hospital (then Asylum), the first formally organized school in any hospital for mental diseases.

The employment of women as nurses in the British Army in the Crimea conflicted with the organized methods of the military

service and met at first with considerable opposition. The establishment of training schools in general hospitals also had to overcome objections from visiting physicians and surgeons who preferred the old régime. All were soon convinced of the great improvement in effected nursing; but so far as is known no general hospital prior to 1878 of its own initiative had established such a school. The Boston City Hospital school was established in that year. The school at St. Thomas Hospital and all others previous to that of the Boston City Hospital were organized outside the hospitals, to which they furnished nursing, and were financed by private benevolence. But there is a limit to such benevolence. The schools themselves as a rule could not be self-supporting, for there is little demand for the services of one that charges even a moderate fee for board and tuition. There is no pecuniary profit in the business of education, and had we then continued to be dependent, though only in part, on charity for their instruction, the supply of nurses would indeed be limited. There could be only a few schools and these in the largest cities. But private enterprise having furnished the means for demonstrating the value of the work, it has been the privilege of the hospitals themselves to take it up and greatly extend it. Only the desire of hospitals to improve the nursing service for their patients and their willingness to enter the field of education have made possible a most honorable profession for so many young men and women with a fair preliminary education.

The Boston City Hospital was the second general hospital to have a medical superintendent, the Massachusetts General Hospital where one of the first training schools in America was established in 1873 having been the first. It was not practicable to organize for the City Hospital a like association of benevolent persons to support a school for its nurses. It had required some years of discipline and gradual preparation to improve the character of the service to make it fit for training; and it was believed that the best results could be gained by keeping the nursing service as a regular department of the hospital. This plan was adopted with the approval of the trustees; the first class was made up of the best nurses already a number of years in the service with others who entered it later and were promised a course of training. The venture was made immediately successful by Linda Richards as superintendent of nurses and matron of the hospital. The form of

organization under a medical superintendent proving possible in two hospitals, it afterwards became general in institutions of all kinds and degrees, with physicians in the larger hospitals and trained nurses in the smaller ones. Such medical reorganization had a deeper purport than the participants in it knew. It meant adapting such experience as is gained in military hospital training to the management of a medical business in a civil hospital, thus creating a unified authority able to regard the service to the sick as the prime object and to make contributive to it all other interests. But while all these internal interests were incidental to the main purpose, efficiency demanded harmony of co-operation; this meant a thoughtful and just regard for the physical, mental, moral, social, and domestic interests of the various individuals—men and women, older and younger, in a great human family under one roof. Out of the welding together of all such interests and activities there comes unity of purpose and directness of aim, that make accomplishment simply a logical sequence.

The McLean Hospital, two years later, like all hospitals for the insane, had the same complex conditions of service and social life, only in a far more emphatic form. In this regard indeed, at that time, the asylums had the advantage over the general hospitals of having resident physicians in charge; this had been the rule with few exceptions since their early days, beginning with Wyman of McLean in 1818, and it was this that gave America the leadership till the middle of the century when, through the long contested administration-reform, the English institutions had become generally free of the domination by wardens and keepers inherited from the prison system of the 18th century. Thus it was that in 1880 the asylums had long been in a better condition for nursing reform than the general hospitals; by reason of the fact of having medical superintendents. This fact was due to the established recognition of the essential difference between the two types of institutions—in the general hospitals the patients are comparatively transient subjects of care and treatment—sane and orderly in behavior; in the asylums the patients are longer resident in the most favorable cases, and for the most part they are comparatively permanent inmates of a socially organized household that becomes responsible for constant supervision of their mental and moral welfare, and

protection against emergencies. Progress in treatment requires constant attention to their social relations; and the test of long experience proves the essential need of attendance by a resident staff. It was under such conditions that, in regard to their proper medical organization and control, the asylums were better hospitalized with the conditions of progress than the general hospitals themselves. Thus tracing the history of the transition it was only necessary to transfer the previous special experience gained in the City Hospital and adapt it to establishing a school for nurses in a hospital for the insane. In the practical interest of the nurse the most essential principles involved had been found to demand two requirements: (1) To give the nurse, in fair exchange for her service, a respectable profession, remunerative enough to satisfy her wholesome interest in provision for the future of herself and often of others likely to become dependent upon her; (2) To stimulate the natural motherliness of the nurse, through which her womanly sympathy is at once enlisted, by teaching her what to do to relieve bodily and mental suffering. It was recognized that the scope of every plan of teaching had been too limited; it did not go beyond the idea of improving the attendance upon the patients immediately concerned.

Beginning with the year 1880, the first step at the McLean Hospital was to introduce into the attendants' work the regular methods of the wards of a general hospital—the "manipulations of nursing," in all possible ways. The "attendants" were called *nurses,* and the "boarders" *patients.* To stimulate the expectation of profitable employment in private nursing, nearly fifty nurses, in the years 1880-5, were allowed leave of absence from time to time to attend private cases. While the instruction was being carried on by these preliminary methods, the study of the situation led to the conclusion that the perpetuity of the work depended upon its having a definite organization by placing the school under the charge of a special superintendent, to carry on the substantial part of the teaching, and to maintain with her assistants an organized system. Such an organization was made formal at the McLean Hospital in 1882, the date to which the founding of the school is assigned; the processes of development were a continuance, however, on the same lines as before actually begun in 1880; there were no lectures till later, the continuity of the system of instruc-

tion with its necessary details being mainly sustained by services other than those of the physicians; the training of instructors was needed. Women trained in general nursing had already been employed in two or three men's wards by Dr. Jelly, in 1877, with duties much like those of companions. Early in the development of the system of training, experienced nurses from the women's department of the hospital were placed in men's wards, in charge of all the duties belonging to the "mistress of a household," and with them other young women as ward maids, in the manner of the service of a ward in a general hospital. This plan was entirely successful and most beneficial in its effects.

Another most essential conclusion was reached during this period of the gradual development of the school. It came to be believed that there would be no adequate field for the professional employment of the product of the school as *specialist* nurses in the public service. It was determined therefore to give the pupil nurses a course of instruction covering as much as possible that of a general hospital training. In a comparatively small hospital like McLean this seemed difficult at the outset, but it was held that in the large hospital for the insane, with the possibility of special "infirmary" and "hospital" wards, there would be sufficient material for instruction in the practice as well as the principles of general nursing. In 1884 the essential methods of instruction had become well determined and established—also the probability of a considerable demand for the nurses so trained; then regular courses of weekly lectures for senior and junior classes were begun by the medical staff and continued during eight months of the school year. The special exercises heretofore conducted by the superintendent of nurses and her assistants were further developed, with instruction in surgical "first-aid," etc., by assistant physicians. The work of a full curriculum of two years was then in full operation and continued without interruption thereafter; the instruction was largely devoted to general nursing with constant reference to the application of principles and methods to the nursing of the insane. The women graduates who chose to do so were permitted to take an additional year of training at the Massachusetts General Hospital. Early in 1886 five nurses were graduated who had been from three to four years under training; later in the year 10 others made the total product of the year 15 nurses. Classes of men were

begun in 1886; and in 1890 the product of the school in graduates aggregated 70 women and 22 men. In the latter year only 22 of the graduates remained in the service; but the general success of those who had gone out had great influence in giving the school a standard of attractiveness, ever after maintained.

The establishment of other schools came immediately after that of the McLean Hospital. Following its class of 1886, a class was graduated at the Buffalo Hospital, under Granger's instruction, chiefly in lectures by himself in a course of two years; in that year three schools were newly established, respectively, by Wise, Dewey, and Hinckley; they were followed in 1888 by Bancroft, and in 1889 by Page. By 1906, 62 schools in hospitals for the insane could be enumerated. While their requirements had not the uniformity that could be desired, there has been great advancement in that regard; the tendency is to increase the course of training to three years, and to keep up with the progress in the general hospitals. As in the McLean Hospital school, there has been a positive tendency in all the succeeding ones to qualify the graduates for general nursing, on the principle that requires the medical student intending to be a specialist to ground himself in the general knowledge of his profession. Experience has shown that, in this combination of training, these factors do not conflict; the primary and most general requisite in the nurse is perfection in her *personal* relations with the patient, and this is best attained in mental nursing; even though the nurse should ultimately prefer bodily nursing she does not forget the former when it is followed by the really specialist training in the care of surgical and medical cases in a hospital for "general" diseases. The personal training is the most general. This characteristic of the insane hospital training schools in the United States, differing radically in this regard from the British system, stimulates and promotes the strong movement that has been going on in them toward a more complete hospitalization of the institutions themselves. The broader training of the nurses reacts upon the instructor; he who teaches learns. While the interest of physicians in the hospitals in surgery and general medicine is not unique here, it is probably more general. The increase has been notable during the last fifteen years in the provision made for the surgical treatment of the insane in the large institutions, not only in respect to gynecological surgery but for the relief of all

remediable conditions; the well-furnished "surgery" is more common. The broader training of the nurse is both a consequence and an aid—a supply creating a demand.

SUMMARY.

In the United States the history of nursing in the hospitals for the insane includes that of humane attendance, which was an essential part of the great reform of Pinel and Tuke. These hospitals were in advance of the general hospitals during the first half century, on both continents, through the earnest and constant efforts of the alienists to give the insane the kind of intelligent and sympathetic personal service that springs from the higher motives; but little improvement was made beyond the grade of "ordinary attendants." In the third quarter of the century nursing reform was established, and widely extended in the general hospitals by educating the nurse and giving her a respectable profession. This proved, as a sequence perhaps not foreseen by Miss Nightingale, to be remunerative in private life and an inducement to attract worthy persons to the service of the general hospitals. A concurrent advancement was not gained for the insane, in the quarter-century 1850 to 1875, in spite of the renewed efforts of the alienists, because they did not see the way to offer a like inducement; their attempts were aimed too much at creating a specialist attendant for their own service, without sufficient provision for training a nurse qualified for the public service beyond the narrow scope of mental nursing. This was the situation both in the United States and older countries, a little later than the beginning of the last quarter-century.

The success of the effort in the United States begun in 1880, resulting in the permanent establishment of a training school for nurses for the insane, was gained by the accomplishment of two definitely planned purposes: (1) By organizing a school with a sufficient staff of teachers and officers to insure its perpetuity and enable it to offer an adequate course of training to lead to a profession. (2) By insisting upon giving a broad training to qualify the pupil for general nursing; it was the proven success of this that determined the larger usefulness and ready employment of the nurse in the public service. The hospital lost nothing by making it worth something to the nurse to come to it. These two

provisions appear to have been the most potent factors in bridging the long existing difficulty that stayed the progress of the alienists. It was on such foundations that, in twenty years, sixty-two schools were established, upon the independent initiative of their founders.

The result is that the adoption of a plan of training with such a scope is contributing to the more rapid and complete hospitalization of the institutions for the insane in the United States. These schools possess a power of growth, and by maintaining their kinship in the broad field of general medicine they are themselves stimulated to keep pace with the advancement in the general hospital schools. Many of the nurses from the former go for a time to a general hospital to specialize in surgery, etc.; or to lying-in or other hospitals. With the increasing practice in the schools of employing nurses from other schools, there is freedom for the adaptation of the nurse to her calling according to her personal qualifications and inclinations, much like that of the medical student. The disposition of the "nursing world" to relegate the "mental nurse" to an isolated, specialist class has failed; she has won her place, and is now recognized by the organized associations as having the standing of a nurse, when properly trained. All these things help to raise and hold up the standard of the schools for nursing in hospitals for the insane.

Great interest belongs to the tracing of the factors of development of these schools for nursing; they are *growing up* to their contributive place in the great movement in those hospitals which is surely leading ultimately, not to heroic surgery to cure insanity, but to the recognition and relief of all diseases that afflict the insane, making the field of psychiatry as broad as that of general medicine. Yet this history of modern nursing reform is but one of the many aspects revealed in a still broader view of the march of progress in this field of personal service for the weaker half of humanity, in many lines concurrent with nursing reform. Having found a common aim they tend to merge, though at first having little seeming kinship. Beginning as a modern movement in the field of religious effort, social service in the larger conception of its province has come to include many formerly separate forms of philanthropic service. For many years there have been out-patient services for mental disorders, and organized methods for "after-care" and "boarding-out," and trial "visits" at home in convalescence.

The great expansion in recent years of social service work in general hospitals is making them more perfectly hospitalized in all their departments, and there is a like uplift and new inspiration in the early care of the insane through the remarkable development of the new psychopathic institutions with their higher order of attainment; they are the outcome of forces long at work—the culmination of efforts to gain long desired needs in psychiatry. Thus the improving care of the mentally sick, being brought on its own part to a higher level of hospitalization, is calculated to return reciprocal aid in a great unifying extension of social service, through the qualifications of educated women that have been gained in mental nursing. In the working together for good of all these forces not only is there a recognition of a larger place for psychiatry in general medicine, but also of its own share in the highest service of preventive medicine.

II.

FIRST TRAINING SCHOOL FOR ATTENDANTS AT THE BUFFALO STATE HOSPITAL (ASYLUM), 1883-1886.[1]

In the year 1883 instruction of women attendants at the Buffalo State Asylum, now the Buffalo State Hospital, was begun. At first it was a general instruction upon the rules, and more particularly upon the care of the insane. It was experimental in character, but with hopes that a regular training school might be organized. When it soon appeared that there was a true interest, a class of women was formed and a regular course of instruction was adopted.

In 1885 a similar regular instruction was begun for men attendants. In 1885 the Board of Managers gave official recognition to the school and a circular was printed setting forth its object, the instruction given, the qualifications necessary for admission and the privileges received. It stated: "All attendants shall be instructed in the rules and regulations of the asylum, and in the duties of their several positions. The special training of the school will be given in such studies and methods for the special work of attendants upon the insane and for nursing the sick. The course will be two years, and will consist of lectures and clinical instructions."

All applicants were required to pass a state civil service examination and to undergo a probationary period of two months.

There was to be an examination at the end of the first and second years, and it was provided that the attendants, if qualified, "shall receive a certificate from the institution as well-qualified nurses and attendants upon the insane."

Dr. J. B. Andrews, the superintendent, in his report of 1885, says: "Thus was inaugurated the first training school established in any state asylum for the insane in this country, and the only one

[1] By William D. Granger, M. D., Vernon House, Bronxville, N. Y.

of which we have any knowledge that provides for the instruction of both men and women attendants."

The State Board of Charities of the State of New York by resolution cordially approved and commended the action of the managers of the Buffalo State Asylum and the plan of instruction outlined in their circular, and regarded the establishment of the school as the beginning of a new era in the selection and proper qualification of attendants upon the insane.

An effort was made to give instruction to every attendant, and in 1885 all men and women attendants but two were members of the school.

On April 30, 1886, a class of seven was graduated.[1] This followed an examination held in the presence of the president and the two medical members of the Board of Managers. There were six sets of questions, viz., upon the nervous system, the mind and mental phenomena, midwifery and monthly nursing, epilepsy, insanity and the care of the insane, general medicine and drugs. The address was given by Dr. Stephen Smith, State Commissioner in Lunacy. Hon. William P. Letchworth, president of the New York State Board of Charities, Rt. Rev. Bishop Ryan, and many professional men and others from Buffalo, interested in the movement, were present. Papers were read by graduates on the following topics: "The Value of Regular Administration of Food," "Hallucinations and Illusions Among the Insane," "The Relation of Attendants to Patients."

Ample extracts from these papers are to be found in the *Journal of Insanity*, July, 1886, together with many of the questions asked in the examination and Dr. Smith's address. The papers of the graduates were honest efforts, creditable to the writers, and whoever reads them will acknowledge that they compare favorably with any that can now be produced. I was able to follow the after life of several of the graduates. They were fine women and were most successful in their nursing career, while they freely bore testimony to the great value of their training as fitting them for their calling, developing their character and their conception of the dignity of their work as nurses.

[1] Dr. A. W. Hurd, now superintendent, then second assistant, was associated in the instruction of this class.

The following are some of the questions asked:

Insanity (38 questions).

Give some of the physical conditions of acute mania: of acute melancholia; detail the care such patients need. What is a delusion; an insane delusion; a fixed delusion; delusions of suspicion? What are hallucinations; illusions? What patients are likely to choke themselves?

Epilepsy (15 questions).

What are characteristics of a fit? Conditions liable to follow a fit? What is to be done in a fit?

General Questions (41 questions).

What is asphyxia? What should be done in drowning, hanging, suffocation? How is artificial respiration performed? Give method of applying moist heat—a turpentine stupe fomentation—poultices—a mustard plaster. What is a deodorizer; an antiseptic, and a disinfectant? Give apothecary's weights; dose of powdered opium; tincture of opium, morphine; symptoms and treatment of opium poisoning; after what injuries should alcohol be avoided?

Aside from his office as commissioner, Dr. Smith was singularly qualified to speak. He was a successful surgeon in New York City and had been for years a teacher in a metropolitan medical school: he was connected as visiting surgeon with general hospitals, and especially had been identified with the establishment of the newly created training school at Bellevue Hospital. He also possessed exceptional knowledge and experience. He had an intimate knowledge of the kind of nurse (so-called) employed in general hospitals before the day of training schools and he had witnessed the establishment and development of training schools. He was also well acquainted with the untrained asylum attendant; he had watched our efforts at Buffalo most carefully, and he knew the graduates personally.

Dr. Smith in opening said: "When I began my official inspection of the institutions for the insane, I entertained no friendly opinion towards their management. And especially did I regard the attendants as a class of men and women probably much below the average nurses in hospitals with which I am connected. I would be recreant to my sense of justice did I not in this place bear willing and emphatic testimony to the general good character of the at-

tendants in the asylums. I have seen them in every capacity and tested them by every suitable method day and night, and I know of no class of employees who could have better sustained the scrutiny.

"In the care of the sick aptitude for nursing has hitherto been regarded as the only qualification. But within ten years to aptitude has been added training by a systematic course of instruction, and the result is the old-grade nurse has been completely driven from the field. And if the nurse of one sick of a physical disease is so much improved by training, how infinitely more important it it that those who are to administer to a mind diseased should have special training. I cannot, therefore, too much commend this first effort to thoroughly prepare attendants for their duties. In fact, I have no doubt that within a decade no attendant will be employed in a state asylum in this state who has not certificates from a training school."

To the managers he said: "To be pioneer of a far-reaching reform, not only in the original conception of its underlying principles, but in the organization and perfection of the scheme by which its benefits are to be secured, is the highest honor to which man can attain. It is, then, with no ordinary pleasure, and with a profound sense of duty, that in this public capacity and on this auspicious occasion, I acknowledge the obligation of the state, of every citizen interested in the best care of the insane, and of the insane themselves, to the founders and promoters of this school."

It was no small undertaking to establish such a training school in 1883. Training schools for nurses in general hospitals had not then fully passed their first stage, and for one in an insane asylum there was no guide. Fortunately, we did not make a plan; we simply began by testing ourselves and the attendants for the first year. In this way we were able to establish systematic training and in two years to instruct and graduate a class.

In 1883 Dr. W. G. Thompson published a small book of 57 pages, "Training Schools for Nurses," Putnam. The first part of the book is a description of the old and new system, a defense against the "opposition to the new system," and a description of what a training school is, and what a trained nurse is or should be. At the time of publication there were 23 training schools in the country, some just established. Several schools not connected with

any hospital were established in different cities and instruction given, while an effort was made to secure practical work in hospitals. Only 11 schools in general hospitals had graduated nurses and the total number of graduates was less than 600. These schools, with graduates directly connected with general hospitals, were either in New England or in New York State. The requirements were a good common school education, reasonable age, and, of course, good character. Instruction was from 18 months to 2 years. Unfortunately schools were pressed for money and during the second year nurses were sent out to do private nursing, thereby losing much instruction but turning into the schools a good many thousand dollars thus earned. Nurses in training were paid $5 to $15 a month, besides being given board and lodging. Two or three hospitals only had special homes and most schools had to adopt any make-shift to give living quarters. Many wards were without nurses from the school, and nursing on men's wards was little practiced and the desirability of it even questioned.

Two text books of instruction only had been published. One was "A Hand-Book of Nursing," published "under the direction of the Training School for Nurses, State Hospital, New Haven," 1882; the author's name was not given, but introductions had been supplied by Presidents Porter and Woolsey of Yale College. The other was, "A Manual of Nursing for the Training School for Nurses Attached to Bellevue Hospital," 1882. In the preface it is stated that "the credit of editing and compiling belongs to Dr. Victoria White." Miss Clara Weeks' book was published in 1885. These books were elementary in construction, and covered about all forms of nursing, except that of insanity and nervous diseases. At the present time they would be called primers. They were sufficient for their day, and, though small, were works of great excellence.

These pioneer schools did thoroughly good work under great difficulties, and graduated well trained nurses. In so far as we could find out their ways and methods, they served as our guides, but they were far from being established and systematized, as are the schools at the present time, and it was difficult to obtain accurate information regarding them.

Dr. Smith's prediction that within a decade no attendant would be employed in a state asylum in New York who had not certificates

from a training school, was not fulfilled. I always believed that had our New York institutions remained as when he spoke all attendants would, as he said, be in training or graduates. But with the coming of state care, the many problems to be solved, more pressing than training, and the rapid increase in the number of the insane in different hospitals, prevented the fulfillment of this hope.

I would call attention to the circular of the managers. In this it will be seen that the plan was to give a course of instruction to those not entering the training school. "All attendants," it reads, "shall be instructed in the rules and regulations and in the duties of their several positions." In addition the training school was established. A full course of instruction was established for attendants with good results. I have always advocated that in the establishment of training schools the attendants should not be neglected. That they will respond to such instruction and be greatly improved by it, I know from experience, while the benefits to the hospital go without saying.

During the three formative years of this school three text books for attendants were issued. The first was a "Handbook for the Instruction of Attendants on the Insane," 1884. It was prepared by a committee of the British Medico-Psychological Association, Dr. A. Campbell Clark being the "Convener of the Committee." Another was "Lectures on the Care and Treatment of the Insane, for the Instruction of Attendants and Nurses." By W. C. Williams, M. D., Sydney, N. S. W., Government Printer, 1885. The third, by the writer of this article, was "How to Care for the Insane: A Manual for Nurses," Putnam, 1886. These three text books, from three widely separated English speaking localities, were voices of the time, calling for the training of attendants. So far as I know, each book was written without knowledge of the other on the part of the authors.

At the meeting of the American Medico-Psychological Association, then the Association of Medical Superintendents, held at Lexington, Ky., 1886, I read a paper on "The Establishment of Training Schools in Asylums, and the Systematic Instruction of Attendants."

Dr. George T. Tuttle, then first assistant at McLean, opened the discussion, giving an account of the school in that institution.

The presentation of the subject by Dr. Tuttle and myself, and its immediate approval by the superintendents, have led me to consider this meeting as the birthplace of training schools in our hospitals for the insane, not only in this country, but elsewhere.

It must, however, be confessed that training schools in institutions for the insane have not developed as have those of general hospitals. In 1909-10 there were employed in the New York State hospitals over 700 graduates, over 500 pupils in training and a little more than 2000 attendants. It is doubtful if 500 pupils in training can keep good the 700 graduates in institutions. The presence of 2000 attendants points to the failure of the institutions to afford instruction sufficient to attract those employees who demand instruction, and to bring to the service persons qualified for it.

The reasons for failures are many. The increased size of the institutions; the many duties of the superintendent, with enforced absence from close work and non-acquaintance with ward employees; the over-worked medical staff; the large farms and scattered buildings; absence of concentration of clinical material, of medical work and of nurse instruction; and, more than any of these reasons, the effect of all combined has been to prevent the thorough organization of the schools. The schools too often are of secondary importance, or rather are crowded out of the first rank, in the mind or inclination of the superintendent and staff.

A training school in a general hospital is a department so organized as to stand apart from its general management in a measure. The superintendent of nurses is responsible for the school, has an authority over it and its individual members. She provides an efficient corps of nurses for the wards, and maintains the efficiency of the school. She is largely independent of control and the success of the school is due to her efforts.

This cannot always be done in insane hospitals, but it can be approached and great power and responsibility can be placed in the hands of a fully capable superintendent. But, unless such a plan is worked out, and the schools are elevated to the first rank, the plan in the New York State hospitals will fail in part and the full success of the schools will not be assured.

As a manager of the Mohansic State Hospital, I have written out a plan for that hospital too cumbersome to print. I have

endeavored to concentrate all the clinical work, making as a basis a building for the clinical director and the medical staff, with its laboratories and conveniences for research work. Round about is to be placed a reception building, a psychopathic building, the medical and surgical hospital, buildings for the infirm and all needing special care, a fully equipped building for "out-patients," where all ambulant cases of the hospital may be received, a building or buildings to which different classes or groups or patients may be brought for prolonged and careful study, with buildings for employment and for scientific re-education. I would have a building for nurses providing quarters for as many as possible, where classes could be gathered and changed. This would be their headquarters, where the discipline, in the broadest sense of the word, would be carried out, every structural facility for instruction would be provided, while clinical instruction and classified ward work would be joined to didactic instruction. Not only would a capable superintendent preside, but medical men and women should be relieved of other duties to give instruction. If this could be done, the training school would attract students and the school would take its place among the things of first importance.

That something must be done, if our schools are to take a high rank, so as to compare favorably with schools in general hospitals, is evident. To reorganize our training schools, more than increased pay, nurses' homes, a club house or special privileges, are necessary. Provision must be made in the greatest degree possible for the clinical instruction of nurses in medicine and surgery, and in all branches of the application and art of nursing. If proper provision is made for that large class not requiring special hospital care, so that concentration of effort can be given to all requiring special care, it will, I believe, work such an interest in the medical staff that they will make a demand that cannot be withstood for thoroughly trained nurses, and be satisfied with nothing less. In some such way the schools will come into their own, and then all things necessary will be added unto them.

The time has come when, if we are to have real hospitals for the care of the insane, we must have trained nurses for the immediate personal care of each patient. To accomplish this, it is necessary, while caring for all classes of the insane, to build in true hospital construction for those needing special care, and bring such build-

ings near enough together to become headquarters for the purely clinical and scientific administration, for the concentrated effort of the staff, thus making a training school necessary, something that must be in the front rank—and never neglected. Much of the benefit of the best clinical oversight must be lacking to epileptic and tuberculous patients placed in buildings two miles removed from the medical center, while the benefit to be obtained from them as a means of instruction in a training school is entirely lost.

We must never forget that the loss entailed by the absence of structural arrangements is greater for the patients. They lose something which is theirs by right and which the state is bound to provide, for without such construction it is impossible for them to have the best clinical oversight and they are deprived of the services of a trained nurse. No patient, public or private, would go into a general hospital if a trained nurse was denied him. The public demands, and has built for it, hospitals structurally arranged for individual treatment, even to the last word.

CHAPTER VIII

PRIVATE CARE OF THE INSANE

I.

PRIVATE CARE OF THE INSANE.

The care of the insane in families or institutions at the personal expense of relatives, friends or guardians, in other words, the private care of insane patients, has existed from early days in the United States.

In a discussion on the subject in one of the meetings of the Association an interesting reminiscence was given by Dr. Isaac Ray of the condition and management of an institution which was in operation in New England in the latter part of the eighteenth century, and undoubtedly there were other similar establishments.

An institution such as he described probably could not receive a license to-day from any Lunacy Commission, Board of Control or Board of Public Charities. As such places of detention were under no adequate supervision they could not fail to be under suspicion because insufficiently equipped and generally conducted by inexperienced physicians and unfeeling attendants.

There was also reason to fear that persons responsible for the support of insane relatives, especially if the latter were of the chronic and incurable class, might from motives of economy seek private treatment for them at a low cost. The experience of New York showed that when the statute requiring the insane be treated at Bloomingdale Hospital was amended to permit relatives and guardians to remove them to private care, the resultant abuse and neglect became such a crying evil as to require a restoration of the former statute which made treatment at Bloomingdale compulsory.

It is not strange that such objectionable form of private care was early frowned upon by philanthropists and that in Pennsylvania and New York at least an appeal was made to the public for funds for the erection of general hospitals for the especial care not only of the sick and helpless but also *of the insane.* The Pennsylvania Hospital in Philadelphia was chartered for this purpose, as was also the New York Hospital. It is interesting to note that in the Pennsylvania Hospital patients were received from the beginning at the expense of their friends. The wife of Stephen Girard

was thus cared for in the Pennsylvania Hospital for many years, and eventually when she died was buried upon its grounds. Stephen Girard was then regarded the most wealthy merchant in the United States and yet his wife was cared for at a charitable institution at private expense. At the New York Hospital a separate building was erected for the care of private patients and pauper patients as well who were received under contract with superintendents of the poor of the different counties. Later when the Friends' Asylum, at Frankford, was erected it received private patients in a similar way; the same was true of the Williamsburg Hospital in Virginia, and the South Carolina Hospital at Columbia. In Massachusetts, Connecticut, Rhode Island, Vermont and New Hampshire the original institutions like the Brattleboro Retreat, the McLean Hospital, the Butler Hospital, the New Hampshire Hospital, all corporate hospitals, were in effect at first private institutions; they admitted patients at both public and private expense. Later when the Utica State Hospital was opened in 1843, patients were admitted at the expense of counties and also of individuals, many being supported in the latter manner.

This practice was extended to succeeding state institutions in New York as they were built and continued until 1894. The state hospitals of New Jersey, Pennsylvania, Maryland and Michigan, all received patients at private expense. Such patients generally received private apartments, a more varied diet, and greater privileges than other patients. In return they paid a higher rate than was paid for the care of county, township or state patients. It is unquestionable that there was an unfairness in this arrangement, especially when it became necessary to ask for the removal of chronic patients to county hospitals in order to create room for acute cases. For such removals indigent patients were more often selected while those who paid more liberally for their treatment were sometimes retained at the state institutions, although of the chronic class.

It is interesting to recall that considerable prejudice for many years existed against institutions owned and managed by individuals. In a paper presented to the Association in 1860 by the late Edward Jarvis and published in the *American Journal of Insanity* for July of that year, an excellent description of private institutions in England was given. The accompanying declaration as to the

greater utility in the author's opinion of private institutions for certain classes of insane was received with more or less hostile criticism. In the discussion of the paper which followed, men eminent in the care of the insane like Kirkbride, Worthington, Tyler and McFarland criticised the establishment of such institutions and contended that all patients of whatever class were more comfortable, better cared for and had better prospects of recovery in a state or corporate institution than in a private institution. In 1860 so far as is now known the only exclusively private institutions under proprietary control in the country were Sanford Hall on Long Island, and Brigham Hall at Canandaigua, N. Y. Sanford Hall had been in operation for nearly half a century and had given luxurious care to wealthy patients from New York, in a fine old mansion formerly occupied by a distinguished chancellor. Brigham Hall, named after Amariah Brigham, had been organized and opened in 1855 by Dr. George Cook, for many years as assistant at Utica, and Dr. John B. Chapin. Both institutions had excellent methods and although under private ownership were most useful and no reason existed to criticise their management.

Although the general sentiment seemed to be that patients of every sort were better off in a public than a private institution, several who participated in the discussion, notably Dr. Isaac Ray, expressed the belief that certain classes of patients were more comfortable in a private institution. He believed that there were many who no longer needed the discipline of a public institution and were much benefited by personal liberties which could be given to individuals but might not be given to larger numbers. He confessed that he had recommended the removal of a woman from his institution to a private one, so that she might be permitted to have a fire in her room at night and a candle burning at the same time. He believed that the great objection to a private institution was the matter of expense; it was not possible to get as much comfort in a small, cheap private institution as in a large public one. Notwithstanding this dissent the well-nigh universal sentiment of the Association seemed to be unfavorable to private institutions.

In spite of these objections, the time soon came when corporate and semi-private institutions like Bloomingdale, McLean, Brattleboro, Hartford Retreat and the Butler Hospital, became private institutions because of the establishment of public institutions in

their various states for the care of indigent patients, who had formerly been sent to them under contract. This necessitated a rearrangement of these institutions for the better accommodation of patients wholly at private expense, and they have been restricted to care of such patients for the past quarter of a century.

The later policy also of many state institutions, as for example, in New York under the Lunacy Commission which discouraged the practice of receiving private patients, had much to do with the establishment of small private institutions in several states after the adoption of state care. In states where accommodation for patients under the care of the state was lacking it was manifestly unjust to fill up the hospitals with paying patients to the exclusion of those who were in poorhouses or county receptacles. There has accordingly grown up in New York a large number of private institutions of varying size. In Connecticut, on the edge of New York, several large institutions for the care of private patients have been developed for a similar reason.

Another factor which has unquestionably influenced the erection and development of private institutions has been the great increase of wealth in the United States. Patients were formerly placed in public institutions at private expense as a measure of economy, but the growth of fortunes and a feeling which exists among many persons that there is less stigma attached to private institutions because of less publicity among its inmates, often leads wealthy families to place their dependent friends under private care. Many also have a feeling that the medical care and nursing received at private institutions are better or at least more individualized than in large institutions, crowded with patients of different classes.

The care of private patients in this country is now assumed by three different classes of institutions:

1. Institutions under the charge of incorporated hospitals associated as departments with general hospitals for the care of general diseases, such as the McLean Hospital, the Bloomingdale Hospital and the Pennsylvania Hospital.

2. Others like the Butler Hospital, the Sheppard and Enoch Pratt Hospital, the Brattleboro Retreat, and the Hartford Retreat, are incorporated hospitals, arranged exclusively for the care of patients of a private class. All of them have funds at their disposal which may be used for the benefit of persons in straitened circumstances,

but patients are not treated without charge unless arrangements can be made for the use of such funds. Many undoubtedly are treated at less than actual cost, but the majority of patients pay for their care and treatment.

3. A third class of institutions is exclusively under private ownership and control, although often incorporated. These institutions are intended to produce an income for share-holders or proprietors, and are not in any sense to be considered charities. Of these institutions there are many of excellent standing in the wealthier states like New York, Michigan, Wisconsin, Illinois, California and other states. There are also a number of institutions which have a certain resemblance to these under the charge of one or more of the religious orders of the Roman Catholic Church, such as the Mount Hope Retreat near Baltimore, St. Vincent's Institution near New York, Providence Retreat near Buffalo, St. Joseph's Retreat in Detroit and St. Vincent's Hospital at St. Louis. Some of these have arrangements with the municipalities in which they are situated or adjoining them, for the care of patients of the dependent class, but all of them have facilities for the care of private patients and receive an income from it, which has enabled them to spend considerable sums of money in the development of their institutions. Another similar class of private institutions consists of those which are maintained by physicians as a means of livelihood. Many of them originally started in private houses and have developed into well-built, convenient, well-equipped and acceptable and comfortable places for the care of the insane.

An effort has been made to get a list of all these institutions with a description of their buildings and facilities. It is a matter of regret to the committee that it has been unsuccessful in getting a complete list of the latter institutions.

CHAPTER IX

COMMITMENT AND DISCHARGE
VOLUNTARY ADMISSIONS
CRIMINAL INSANE

I.

GROWTH OF THE LAW OF INSANITY.

The right to deprive an insane person of his liberty existed in England under the common law, and was transferred bodily to America when the colonies were established. The provision, however, was originally intended to cover only cases of emergency, where immediate restraint was required and where any delay would be dangerous; hence an insane person, dangerous to himself or others, could be arrested by any one as a matter of public protection and temporarily detained in any suitable place, provided it could be done in a humane manner, until such time as some permanent disposition could be made of him. The authority in this case was limited to the actual necessities of the moment and did not in any way confer the right to keep him in confinement after his paroxysm of excitement had passed. As soon as possible accordingly, after such arrest, judicial proceedings must be instituted to determine the propriety of such detention and to free the person responsible for it from liability to damages for false imprisonment.

In England insane persons might not only be confined but even subjected to harsh treatment if such measures were regarded as necessary for their cure. In fact, the statutes relating to lunacy formally declared that nothing in them should be taken to abridge the power of the Court of Chancery to deal with them, or to prevent any friend or relative from acting as he deemed necessary in the case of persons of unsound mind. It was regarded as justifiable "to confine, bind and beat" them in such manner as might be requisite under the existing circumstances. It was further held that any man was justified in making an assault to restrain the fury of a lunatic and to prevent mischief, while a similar justification was accorded to physicians in attendance on insane persons.

Building upon the common law in England, it was ruled early in the century in New Hampshire that if it was dangerous for an insane person to be at liberty, any one might confine him for a reasonable time without warrant, until proper proceedings could be had for the appointment of a guardian. In Massachusetts, about the year 1845, Chief Justice Shaw uttered the opinion that

the right to restrain insane persons of their liberty is found in the law of humanity, which makes it necessary to confine those who would be dangerous to themselves or to others.

Legal grounds for the commitment of a patient to an institution for the insane were declared to be:

1. That his disease requires restraint and seclusion.

2. That he is dangerous to himself or to others by reason of suicidal or homicidal tendencies or by liability to acts of personal violence during unrestricted intercourse with his fellow men. Proof of such dangerous tendency must be presented and not merely inferred from the fact that he is insane.

3. That he has dangerous and irresistible tendencies to destroy property on a large scale, as by arson, and is a menace to the community.

4. That he is liable to wander about and become lost and to suffer from lack of food or shelter and cannot be properly supervised and controlled at home.

5. And that his disease requires for its proper treatment seclusion, rest and quiet, which can only be afforded in an institution for the insane.

Under the ruling of Chief Justice Shaw in 1845, it was not regarded essential that the patient should have committed actual violence; repeated and frequent recurrence of insane acts without motive sufficient to actuate persons of ordinary senses were considered sufficient evidence of aberration of mind and such aberrations authorized the restraint of the person subject thereto, although he might not have committed any act of violence. In other words the principle of law was laid down that acts of violence were regarded simply as evidence of disease and that if other evidences of mental disease existed, the insanity of the person was sufficiently established and it was not essential that acts of violence should be a prerequisite to admission to an institution.

The legal principle, however, continued to hold that an insane person could be confined in a hospital only for medical treatment; that his confinement was justified only by necessity, and that the right to confine him could be exercised only as long as the necessity for it continued. In short, an insane man could not be deprived of his liberty unless such restraint was necessary or beneficial, and a commission or guardian or the superintendent of the poor could

only confine him when authorized to do so by the court. The right to confine a patient was regarded as distinct from the duty to protect and maintain him and did not necessarily grow out of the fact of his insanity.

In the colonies, however, a modification of the English practice grew out of the fact that there were few and often no proper institutions to which insane persons could be sent. This was especially the case with insane paupers, who were sent to institutions without certificates of insanity by the superintendents of the poor, because the latter, being charged with their care and support, regarded it a matter of indifference whether they were in almshouses or in special institutions for the care of the insane. Their right was not questioned because it was not for the interest of any one to question the legality of the practice. There was no written law for the practice until many years after.

In New York the act creating the State Lunatic Asylum at Utica was the first definite step towards securing the proper commitment of patients to asylums, and even after its enactment it was still customary to send pauper patients to institutions without certificates of insanity or any formality beyond the simple order of the superintendents of the poor, which in fact only guaranteed the payment of necessary expenses. The same practice existed for a long time in some of the Western States; in fact, it was not until after 1870 that the presentation of certificates of insanity from physicians of recognized responsibility was regarded as essential to the commitment of patients throughout the United States. For a long time patients under guardianship were committed by their friends and relatives without any recognition of the fact by a court of record. Even now certain states, *e. g.*, Rhode Island, Maryland, Connecticut, New Hampshire and others, receive private patients in state institutions for the insane without any formality other than the request of the guardian and the certificates of two physicians of recognized responsibility.

It is to be regretted that no connected account can be given of lunacy legislation in the different states, because in the majority of them legislation did not spring up spontaneously, but developed gradually out of the condition of the country, nor was it derived, as in England, from an extension of the provisions of the common law. In nearly every state the earliest statute enacted was brought

bodily from one of the older states. It is deemed desirable to trace the evolution of the present laws of commitment in one or more of the states and to note the gradual strengthening of the safeguards thrown about the irresponsible insane in all proceedings instituted to deprive them of their liberty. It is, therefore, thought proper to give a sketch as far as practicable of the law as it developed in the State of New York, because New York has widely influenced legislation throughout the country.

In New York as a colony the English common law was adopted as it was applicable to the condition of the insane, by which law idiocy or lunacy was a civil disqualification. The law which prevailed in England had equal force in her colonies wherever the legal status of a person became a question for judicial determination. There seems no reason, therefore, why the colonial laws of New York should contain any special legislation relating to insane persons. The first provision, according to Ordronaux, is to be found in Section 5, Chapter 47, Laws of 1787, Statutes of New York, and is entitled "An Act to Reduce the Laws Concerning Wills into a Statute." This act, which declares idiots and persons "of unsane memory" incapable of devising lands, follows the old English act of Edward II. Concerning it Ordronaux remarks:

"Thus, in the case of idiots no allusion is made to them as possible householders having dependent families, or again, to the possibility of their recovery from such an infirmity; while in the case of lunatics both of these conditions are mentioned and provided for. The statute thus regards idiocy as an incurable infirmity *a nativitate*, while in the case of the lunatic it extends its protection over him and his estate only *dum fuit non compos mentis*."

The next statute, from Chapter 31, Laws of 1788, is a re-enactment of Statute 17, Chapter 5, of George II, entitled "An Act for Apprehending and Punishing Disorderly Persons," Section 6. It reads as follows:

WHEREAS, There are sometimes persons who by lunacy or otherwise are furiously mad, or are so far disordered in their senses that they may be dangerous to be permitted to go abroad; therefore,

Be it enacted, That it shall and may be lawful for any two or more justices of the peace to cause such person to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained, if the last place of legal settlement be in such city, or in any town within such county; and if the last legal place of settlement of such

person shall not be in such city or county then such person shall be sent to the place of his or her last settlement, etc.

No further legislation for the insane appears to have been enacted during the succeeding 12 years. In 1800, however, a case arose requiring the intervention of the Legislature in behalf of an insane person convicted of murder, and under sentence of death, which gives an example of the difficulties which were encountered in dealing with the insane in the absence of proper legislation. The Governor not being at that time empowered to grant pardons in such cases, and there being no insane asylums in the state within which the convict could be confined, the Legislature was the only tribunal to which an appeal could be taken for clemency. An act was accordingly passed to cover the case, which is to be found in Chapter 3, Laws of 1800, as "*An Act to Pardon John Pastano for Murder.*"

WHEREAS, John Pastano, at a Court of Oyer and Terminer, held in and for the City and County of New York, on the 19th day of November, 1799, was convicted of the murder of Mary Ann De Castro, and sentenced to be executed accordingly, which execution has been suspended by His Excellency, the Governor, until the 27th day of February. And,

WHEREAS, It appears satisfactorily to the Legislature, from the testimony submitted and discovered since the trial of the said John Pastano, that at the time of the commission of the act aforesaid he was insane, and is therefore a proper object of mercy; therefore,

Be it enacted, etc., That the said John Pastano be and he is hereby fully and absolutely pardoned and discharged from the felony and conviction aforesaid, and all execution and forfeiture thereon. *Provided,* nevertheless, that the said John Pastano shall continue confined in prison until the assurance which has been made of security's being given that he shall be immediately sent to Madeira, where his connexions reside, shall be complied with to the satisfaction of the Mayor or Recorder of the City of New York.

It will be remembered that under the act of 1787 idiots and insane persons were deprived of the power to devise real estate. By the act of 1801 they were also deprived of the power to dispose of personal estates as well.

Chapter 30, Laws of 1801, is very important because it gives to the Chancellor the power to care and provide for the safekeeping of idiots and lunatics and of their real and personal estates, as well as to provide for their maintenance and that of their families by using the money on hand and, if necessary, to sell real estate for

that purpose. It also provides that the estate of any lunatic in case of his recovery shall be restored to him and in case of his death shall descend to his heirs.

The first law for the support of a hospital to take care of insane people was passed in 1806 and was intended as an appropriation to the New York Hospital. It was entitled "*An Act for the Better and More Permanent Support of a Hospital in the City of New York,*" and its purposes were as follows:

WHEREAS, It has become necessary on account of the increasing number of patients in the hospital in the City of New York to enlarge the same by erecting additions thereto for the more convenient accommodation of the sick and disabled, and particularly to provide suitable apartments for the maniacs, adapted to the various forms and degrees of insanity; and

WHEREAS, The said hospital is an institution of great public utility and humanity, as well as the general interests of the state require that fit and adequate provision should be made for the support of such an infirmary for sick and insane persons; therefore, the better to enable the governor of the said hospital, by means of a permanent fund, to maintain and improve the said hospital.

Be it enacted, etc., That the Treasurer of this state shall every year hereafter, until the year one thousand eight hundred and fifty-seven, upon the warrant of the Comptroller, pay to the Treasurer of the society of the hospital, in the City of New York, in America, for the use of the said corporation, in quarterly-yearly payments, out of any moneys in the treasury of this state not otherwise appropriated, the annual sum of $12,500, the first quarterly payment to be made on the first day of May, next, which said annual sum of $12,500 shall become chargeable upon the duties on sales at public auction in the said City of New York.

In an act of 1809, Chapter 90, it was provided that the overseers of the poor of any city or town, with the consent of the common council or of two justices of the peace, shall make a contract with the governors of the New York Hospital for the maintenance and care of all persons who become lunatics and the payment of such sums of money as may be agreed upon to the governors of the hospital by the overseers of the poor and their successors in office. It will be noticed that no provision is made here for the legal commitment of these patients to the hospital. Prior to their becoming insane they were charges upon the town, or city, or county as paupers and the contract with the hospital in no way changed their status in respect to the overseers of the poor. It was made the duty of the overseers of the poor to keep an account of the amount expended for the relief of the insane and it was further provided

that their transfer to the hospital should not in any way change their settlement, but that their legal settlement should remain the same as if they had not been sent to the hospital. Ordronaux says "this is the first legislative enactment in this state making provision for the pauper insane as a distinct class entitled to care and medical treatment in a special hospital."

It is interesting to notice that in a number of states a similar right was conferred upon the superintendents of the poor to send insane paupers to a hospital for the insane without going through the formality of a legal commitment. It is also evident that in other states the possession of such right was inferred, though not conferred by statute, a fact which subsequently led to difficulty and in one instance to a suit against the superintendent of a hospital for receiving an insane pauper without her being accompanied by proper certificates of insanity.[1] In Chapter 294, Laws of 1827, a provision is found that no lunatic shall be confined in any prison, jail or house of correction, nor shall be confined in the same room with any person charged with or convicted of crime, but shall be sent to the asylum in New York (that is, to the New York Hospital) or to the county poorhouse or almshouse or other place provided for the reception of lunatics by the county superintendents.

It is also interesting to notice in the same act a provision to the effect that it shall be the duty of the parents or relatives of any lunatic to support him in the asylum or elsewhere if they are able to do so, but the curious provision is added that no relative shall be liable for such support if he, at his own cost, provide a suitable place for the confinement of such lunatic and shall confine and maintain him in the manner approved by the overseer of the poor of the town. If this be done, it is not lawful to remove such lunatic from the custody of his relatives. It is gratifying to notice that this provision was not re-enacted when the revised statutes were first compiled, since it led, very naturally, to the confinement of insane people in pens and cages, or in unsuitable, unhealthy quarters in private houses or elsewhere as a measure of economy, and unquestionably the privilege was often abused.

In Chapter 82, Laws of 1836, an act was passed to authorize the establishment of the State Lunatic Asylum. The law which provided for the organization of the same State Lunatic Asylum

[1] See page 333.

passed in 1842 contained many clear provisions for the care of the insane.

According to this act, the overseers of the poor of towns (in counties where the distinction between the town and county poor existed), the superintendents of the poor of counties, justices of the peace, and the first judge of the county, or in his absence, any county judge of the degree of counsellor of the Supreme Court might send patients to the asylum. But the laws did not intend that each of these authorities should send patients of every class. The overseers and superintendents of the poor were to send the paupers, and also those who were committed to their charge by justices of the peace as dangerous. The first judge was to send those that were indigent, but not paupers, and the justices of the peace to commit to the care of the overseers or superintendents of the poor for transmission to the asylum, "any person so far disordered in his senses as to endanger his own person or the person and property of others, if permitted to go at large." Judges of the county were to commit those who became insane while in confinement under criminal charges, and those acquitted of crime on the ground of insanity. The superintendents of the poor of counties had the right to send to the asylum, provided it was not full, any insane person in their charge, without instituting any proceedings to prove his insanity, provided the insanity began previous to the passage of the act to organize the asylum, under date of April 7, 1842. Thus the poor were sent to the hospitals without certificates of insanity from physicians or any recognition on the part of the judge of probate or the county judge of the need of an inquiry into the propriety of their commitment. It further provided that indigent patients should be received on the certificates of two physicians as to insanity and a commitment from the judge of probate of the county, the idea seeming to be that the certificates were essential to determine the question of insanity, while the committing order from the judge of probate was to secure free care to an indigent person unable to secure it at his own expense, and to support his family during his attack of insanity. There is reason to think that the provision of law requiring commitment at the hands of a judge of probate was designed especially to secure that justice was done both to the county and to the individual in the matter of treatment at the expense of the county.

No special change was made in the laws providing for the commitment of patients until 1874, when the law was revised and a commissioner in lunacy was appointed to supervise institutions for the insane in place of the Board of State Charities, to which this duty had formerly been assigned. The Commissioner in Lunacy, Dr. John Ordronaux, was appointed to revise and consolidate the statutes of the state relating to the care and custody of the insane. This revision was distinctly an improvement on former acts, because it provided that no person should be confined or committed as a patient to any asylum except upon the certificates of two physicians under oath and that no person should be held in confinement more than five days, unless within that time the certificates were approved by the judge or justice of a court of record of the county or district in which the insane person resided, also that the judge or justice might institute inquiry and take proofs, and even, at his discretion, call a jury to determine the question of insanity. The law of 1874 continued in force until 1889, when the statute providing for the care, custody and inspection of the institutions for the insane was amended so as to provide three commissioners in lunacy instead of one. These commissioners in lunacy were to consist of a physician, a lawyer, and a business man and were to have supervision of the medical and personal care of patients, as well as of their proper commitment to institutions for the insane. They were also charged with the duty of providing for all insane persons in the state institutions, thus doing away with county institutions, which had been the source of many abuses. After a few years it became necessary, in the opinion of the commission, to ask for increased authority, which was conferred, and the Lunacy Commission assumed many duties formerly discharged by the managers of institutions. Up to this time the latter had control of buildings and of the appropriations for the maintenance of patients, the appointment of superintendents and other officers, the supervision of all accounts, the purchase of supplies, and the general management of all institutions. Since that date these varied administrative duties have been discharged by the Lunacy Commission. Within the past year (1912) the name of the commission was changed to that of the State Hospital Commission and certain duties and responsibilities formerly devolving upon it were transferred to the boards of managers. The Lunacy Commission

has relinquished in some degree its power to purchase supplies, and has placed this matter in the hands of a committee composed of the superintendents and officers of institutions.

It is not to be wondered at that the duties assumed by the Lunacy Commission, in its effort to centralize authority, met with more or less opposition on the part of the various institutions. The excellent results obtained are largely due to the fact that the New York law contemplated an expert control of institutions. The medical commissioner in lunacy was required to have had ten years' experience in the care of the insane and was made president of the commission. The lawyer and the business man were also expected to have special fitness. In the board of control established in the West, an effort has been made to do away with the preponderance of medical authority and to establish boards of control upon a business, rather than a professional, basis. This will be more clearly understood when we come to speak of boards of control in greater detail.

Under recent legislation in New York also the predominant position of the medical member of the Lunacy or State Hospital Commission has been abolished and all three members are placed upon an equal footing.

II.

COMMITMENT OF THE INSANE.

It is interesting to note the development of the present law in reference to the commitment of the insane which grew out of the common law in England. As has been stated in another connection, the custody of insane persons was assumed to be part of the police powers of the state, which were not to be exercised unless the insane person became dangerous to himself or others by reason of violent and irresponsible acts. In the exercise of these powers no thought was taken of the possibility of curing him. Custody and care were regarded as essential, not to the care of the insane man himself, but to the welfare and safety of the community, which must be protected from his violent homicidal tendencies, his inclination to arson or his impulse to commit other depredations upon the property rights of others in consequence of his irresponsibility. Hence the right to confine and restrain insane people was assumed under the police powers of the state, but could only be exercised while the person was violent or until it was practicable to make some legal disposition of him.

Under the English law, anybody could arrest a supposedly insane person, provided it was done in a humane manner, and confine him until his condition was inquired into. It was also proper to exercise any degree of violence which might be required to control his irresponsible fury. It was, however, the theory of law that the right to arrest and confine during inquiry did not give the right to *continue to confine indefinitely*, but only until such time as the patient's mental condition could be determined by proper judicial proceedings.

This brings us to the consideration of another fact which is sometimes overlooked. Although a person is clearly insane, his lunacy does not give even his relatives the right to restrain him beyond the period of an emergency until the necessity for his restraint and confinement is determined by a court. No one, in fact, has the right to restrain any insane person more than temporarily until he has authority from a court of competent jurisdiction to do so.

In England paupers as well as dissolute and irresponsible persons were under the custody of the vestries of the Established Church and were cared for as best suited the requirements of their several conditions. A similar provision was extended to this country wherever the Established Church existed, as in Virginia and Maryland. In New England, where there was no Established Church, nor any board of vestrymen or persons charged by ecclesiastical law with the care of the helpless insane, similar duties and powers were conferred originally upon the selectmen of the town and later upon the overseers of the poor. It is of interest to note also that when, after the Revolution, the church in Virginia was disestablished, it became necessary to pass an act to establish overseers of the poor in place of vestries for the care of the indigent. It is apparent that in dealing with the insane in America it was necessary to create a new body of officials in harmony with existing American institutions. When jurisdiction was given to the overseers of the poor to care for the pauper insane, they generally received authority by law to place these patients where they could be cared for most conveniently, as for example in New York, where special authority was given to the overseers of the poor in different counties to make contracts with the New York Hospital for their care in that hospital.

Later, little or no consideration was given to the fact that the insanity of these paupers had not been legally determined. They were cared for under a contract in the New York Hospital in the same manner that they would have been maintained by the superintendents of the poor in their own county almshouses, it being regarded as entirely a question of support and not of legal commitment. This practice was followed in various other states, probably on the initiative of New York. For many years the superintendents of the poor also exercised the right to send patients to the state hospital over their own signatures without any adjudication of the fact of insanity. In fact, up to the present time traces of this method of sending patients to institutions still exist. Under the law of Georgia the certificate of the "ordinary" of the county where an insane negro resides certifying to his condition, mental and pecuniary, is sufficient to secure his admission to the hospital. In North Carolina and Connecticut a parent or guardian of an insane child seems to have the right to place him in a hospital for

the insane upon the certificate of physicians, without any legal adjudication of the question of insanity. This course was pursued in the majority of states for many years and has but recently been discontinued.

Under a strict view of the law no one has any right by virtue of marriage or blood relationship to commit any person to an institution for the insane, nor does the fact of guardianship or the presentation of certificates from competent physicians establishing insanity give any right to confine an insane person in such an institution. In the eyes of the law as at present interpreted, no person can be confined in an institution except by an order of a court of competent jurisdiction.

Ordronaux says that under the common law an insane person might be confined anywhere as a person dangerous to be at large; he might be put in a jail, or house, or pen, or any other place of confinement where he could be kept in safety.

The original law of New York provided that "No lunatic may be confined in any prison, jail or house of correction or confined in the same room with any person charged with or convicted of crime, but he shall be sent to the asylum in New York or to the county poorhouse or almshouse or other place provided for the reception of lunatics by the county superintendent." Subsequently it was provided that no parent or relative of any insane person thus confined shall be liable for his support if he shall provide a suitable place for his confinement, and shall confine and maintain him in such manner as shall be approved by the overseers of the poor of the town and in such case it shall not be lawful to remove him from the custody of his relatives who shall thus provide for him. This proviso put a premium upon bad treatment, neglect and abuse. Its effect upon the care of the insane was so unfortunate that it was soon repealed and the care of the insane at home was not permitted.

Reference has been made to the fact that insane paupers were formerly sent to institutions for the insane over the signatures of the superintendents of the poor without any legal commitment or certificates of physicians as to insanity. In Michigan, in the year 1877, a pauper patient was sent to the Michigan Asylum at Kalamazoo, under an order of this kind from the superintendents of the poor, without any certificate of insanity. Subsequently she brought a suit against the superintendent of the institution alleging that she

had been detained without proper authority, and secured a verdict of $6000 damages. The case was appealed to a higher court and a new trial ordered to determine whether the superintendent of the institution had acted in good faith in receiving her. At the new trial the case was taken from the jury and a verdict ordered on behalf of the defendant, on the ground that his action had been in perfect good faith and that the continued insanity of the patient had rendered it impossible for him, after allowing her to be placed in his custody, to set her at liberty. The judge in taking this action declared that the good faith of the superintendent of the institution in retaining the patient must constantly be recognized, no matter what legal authority had been given in the first place, or what certificates had been brought. It was his duty to decide the question of insanity and necessity of continued confinement of each patient under his care, and if, in his opinion, the necessity for confinement still continued, and he honestly and conscientiously believed that the patient should not be set at liberty, his good faith in retaining such a patient should be a protection in the exercise of his authority as superintendent.

In this connection the question arises as to what degree of danger there should be in the condition of the insane person to justify his continued confinement in an institution. As a matter of fact, many, perhaps the majority of insane people, do not continue in a state in which it is necessarily dangerous for them to be at large, so that the original necessity which demanded their admission to the asylum, hospital or sanitarium does not always continue. The inquiry then presents itself, How dangerous shall a person be? Or, as Ordronaux expresses it, How dangerous to the present and future welfare of the individual is his insanity? The question of cure cannot be disregarded in the answer as well as the fact that incurability may be as great a calamity to the patients as any danger from his irresponsible actions to the community. In deciding upon the necessity for confinement, the decision of the question should rest not only upon the dangerous character of the patient's conduct to others, but also upon the danger of the disease to the patient himself. The view has been expressed by Baron Pollock that the object of the English lunacy acts is not so much to place lunatics in confinement as to restore to a healthy state of mind such as are curable, and to afford comfort and protection to the rest. The

difficulty of ascertaining whether an insane patient be dangerous or not is great, and often can only be determined after close observation extending over a long period of time.

As a result of the "personal liberty bills" which were passed in a number of states following the agitation originated by Mrs. Packard, in Illinois, a provision of law for the jury trial of insane cases in open court after their arrest by the sheriff and prosecution by the district attorney was not uncommon. For many years in Illinois the necessity of a jury trial to determine insanity was prescribed by law and no patient was committed without it. At present the matter of a jury is left to the discretion of the judge unless a jury trial is demanded. In several other states a similar system still exists and patients cannot be committed until the question of insanity has been passed upon by a jury. In some states the proceeding is optional. If a jury is demanded, the fact of insanity must be determined by a jury. The value of a jury trial to determine the existence of insanity seems to have been much overestimated. Where it has been insisted upon it has often resulted in error and has constituted no safeguard to the liberty of the individual or the safety of the community. Under the English law a trial by jury was not regarded essential nor was it in the older states; it being found practicable for the judge to act with equal or greater wisdom, with less delay and without interfering unduly with the liberty of the individual.

Many persons have contended that unless the insane are committed by jury trial they are restrained of their liberty "without due process of law," but it has been clearly pointed out by Ordronaux and others that "due process of law" means the law of the land, so that any law which is properly placed upon the statutes must be considered "due process of law."

In examining the laws of commitment and the procedures under them, I find that in five states of the Union, viz., Colorado, Kentucky, Mississippi, Texas and Wyoming, it is imperative that the commitment of patients shall be after a verdict by a jury.

In four others, viz., Alabama, Massachusetts, Missouri and Wisconsin, a jury is not imperative, but may be impaneled at the discretion of the court. In five states, viz., Georgia, Kansas, Maryland, Michigan and Washington, a jury must be impaneled when demanded by the patient or his counsel.

In one state, Illinois, a jury or a commission must determine the question of insanity and the presence of the insane person in court is at the discretion of the judge.

In several states, when an appeal is taken from the decision of the judge of probate that a person is insane, the appeal must be tried before a jury.

In ten states, viz., Iowa, Kansas, Louisiana, Minnesota, Nebraska, North Dakota, Oklahoma, Pennsylvania, South Dakota and Virginia, the question of insanity is determined by a commission —usually a county commission.

In 24 states, viz., Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Maine, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont and West Virginia, no mention of a jury is made in the law. In the majority of these states the old-fashioned form of admitting patients, clearly traceable to the original act organizing the Utica State Hospital or the scheme of the law prepared about 1850 by Dr. Isaac Ray, may be discovered.

In some of the states, instead of certificates from any physician, or "any reputable physician" as the phrase used to be, special qualifications are insisted upon, which must be certified to by the judge of a court of record.

In California the law provides that there must be at least two medical examiners in each county. In New York, Massachusetts, Michigan and Ohio, the examining physician must possess special qualifications. It is interesting to notice that while at first patients were admitted very loosely, upon certificates of physicians, and little pains were taken to establish the competency of those who made the certificates, at the present time the tendency seems to be strong towards securing expert testimony as to the insanity of a person prior to his admission to a hospital. It is rather interesting to notice that wherever boards of control exist or central executive boards like a lunacy commission, now a hospital commission, in New York, a board of insanity in Massachusetts, a board of administration in Illinois, there is a marked tendency to control the certification of patients. In some states the appointment of commissioners of insanity in each county, consisting of the county judge, a physician and a lawyer, is deemed preferable; in other states com-

missioners of insanity in those counties where institutions for the insane exist are created to pass upon the question of the proper admission of patients and to give a degree of confidence to the public.

It is of interest to observe, however, that in connection with greater care as to the admission and commitment of patients, there is an increasing tendency to open the doors of institutions to voluntary patients. It seems almost an anomaly to legalize the admission of a voluntary patient by his own written application for admission to be treated for a disease, the chief characteristic of which is a condition of irresponsibility.

III.

CONDITIONS OF DISCHARGE.

A brief mention of the conditions of the discharge of patients from the hospital seems necessary; also the matter of the discharge of patients on parole or on probation.

Arizona.—A provision of law exists for the discharge of patients on parole, the only proviso being that no patient guilty of suicidal or homicidal tendencies shall be paroled. Recovered patients are to be discharged upon recovery.

Alabama.—The period of parole or of probationary discharge may be extended to a period of six months. Recovered patients can be discharged upon recovery.

Arkansas.—There is no provision for parole. Recovered patients are discharged and incurable patients also are discharged, if it becomes necessary to find room for other patients.

California.—The superintendent under such restrictions and agreements as he may deem necessary may permit a patient to leave the institution for a period not to exceed six months. Any person held in confinement under an order of the court may, upon satisfactory proof that he is restored to reason, receive an order for his discharge.

Colorado.—The superintendent may grant a probationary discharge. If a patient is restored to reason he must be discharged and the superintendent must notify the judge of the county court. If such discharge is not granted any applicant may present a petition to the county court, whose duty it becomes to appoint two physicians to make further inquiry. If the patient is found to be restored to reason he must be discharged.

Delaware.—The superintendent must discharge, with the consent of the trustees, a patient who has recovered. He is also empowered to return all indigent and incurable insane to the almshouse of the county of their residence.

District of Columbia.—Authority to discharge a recovered patient is vested in the superintendent. He must file a sworn statement with the clerk of the Supreme Court of the District of Columbia that the patient is restored and this statement is sufficient to

authorize the court to restore him to his former legal status as a person of sound mind.

Florida.—Has no legal provision for the discharge or parole of patients.

Georgia.—All recovered patients must be discharged by the superintendent, under rules prescribed by the trustees. The trustees may also discharge, upon the certificate of medical officers, harmless incurable patients.

Idaho.—Patients must be discharged upon recovery.

Illinois.—Patients may be released on parole for any term not exceeding three months. The superintendent may discharge a patient who is not insane or one who has recovered, or one who is so far improved as to be capable of taking care of himself and not unsafe to the public. No person charged with crime may be discharged until notice has been given to the court having jurisdiction of the case. When notified that a patient has been discharged as cured, the judge of any court must make an order restoring the patient to his civil rights. A provision also exists for the after-care of patients by a member of the staff of physicians of the institution whenever the superintendent deems it necessary.

Indiana.—The patient must be discharged by the superintendent when he recovers. If necessary his sanity must be established by an inquest in the same manner as his insanity, or the patient may be discharged to the custody of his friends if they are willing and able to care for him.

Iowa.—Any person who is cured must be discharged by the superintendent with a certificate to that effect, a copy of which is to be forwarded to the clerk of the district court from which the patient was committed. This certificate restores him to his civil rights. Relatives of any unrestored patient can also remove him if he is not dangerous to be at large. No patient under criminal charge or conviction may be discharged without an order from the circuit court.

Kansas.—The board of control may release patients on parole. Authority to discharge is vested in the board of control, but may be delegated to the superintendent. The grounds for discharge must be that the person is not insane, or that he has recovered, or that he is so far improved as to take care of himself, or that his friends request the discharge and in the opinion of the superintendent no

evil consequences are likely to follow it, or that there is no prospect of recovery and his room is needed for another patient. No patient who is violent, dangerous, unusually troublesome or filthy in his habits may be discharged from a state institution and sent back to any county institution. No person who is not recovered or is charged with crime may be discharged until after 10 days' notice to the probate judge. Upon proper notice to the probate judge that the patient is cured, he must order a restoration of his civil rights.

Kentucky.—The superintendent may permit the friends of the patient to remove him permanently or for such length of time as the superintendent may deem prudent. No person is discharged cured except by the authority of the superintendent. Any patient admitted to the hospital under criminal charge must be delivered to the penitentiary or to the jail of the county whence he came, upon recovery.

Louisiana.—Authority to discharge patients upon recovery or for other reasons is vested in the superintendent subject to the order of the respective boards.

Maine.—A temporary leave of absence may be granted to a patient by the superintendent in charge of a guardian, relative or friend for a period not exceeding six months. A patient committed may also be discharged by a justice of the Supreme Court.

Maryland.—Patients may be removed on leave of absence or parole for a period not exceeding 30 days. If the patient remains away 60 days a new commitment is required. Patients may be discharged upon recovery.

Massachusetts.—The State Board of Insanity may permit a patient boarding in a family to leave such custody in charge of a guardian, relative or friend for a period not exceeding one year. The superintendent of the hospital may parole an inmate for six months and receive him again without a new commitment. No unrecovered patient who is violent or dangerous can be discharged.

The superintendent of a public institution when authorized by the trustees or State Board of Insanity, or a judge of probate or justice of the Supreme Court, may discharge an inmate who will be properly cared for elsewhere or whose detention is no longer necessary for his own welfare or the safety of the public.

Michigan.—There is a provision for the parole of patients for 30 days. Patients may be discharged on recovery or if not detrimental

to the public welfare, or if, after a hearing in court, such recovered patient can obtain an order from the court which will grant the restoration of his legal rights.

Minnesota.—Parole is granted to patients for six months. Recovered patients must be discharged.

Mississippi.—Recovered, incurable or harmless patients are discharged.

Missouri.—The superintendent may parole any patients when it seems best for them and may discharge any who are, in his opinion, fully restored to reason.

Montana.—Commissioners of insanity must discharge every person in fit condition to be at large.

Nebraska.—Cured patients must be immediately discharged. Relatives may remove harmless, incurable patients by consent of the board of trustees. Any person except a homicide may be removed to the county of his residence upon an application on the part of his friends. Incurable, harmless patients must be discharged to make room for recent cases.

Nevada.—No provision for parole or discharge is made in Nevada.

New Hampshire.—Any justice of the Supreme Court may parole a patient and may also revoke the parole. Any person may also be discharged by consent of three trustees, by the Commission of Lunacy or by a judge of the Supreme Court.

New Jersey.—On certificate of complete recovery from the director of the hospital, the managers may discharge any patients except those under criminal charge. They may also discharge unrecovered patients or return them to the almshouse of the county. No provision exists for parole.

New Mexico.—Patients must be discharged when they recover.

New York.—Patients may be paroled for six months, during which time the hospital is not liable for their expenses. The superintendent may discharge any recovered person except a criminal. He may also discharge a dotard, one not insane, or an unrecovered patient, if he deems it safe for him to be at large and his friends are willing to take care of him. Any judge of a court of record may discharge after a hearing. The Lunacy Commission may discharge all patients improperly detained.

North Carolina.—A probationary discharge may be given for 30 days by the superintendent. Three directors of the hospital may

discharge a patient found to be sane, or recovered, or safe to be at large.

North Dakota.—A cured patient is to be discharged. Incurable, harmless persons may be removed by relatives with the consent of the trustees. Any person uncured and deemed unsafe to go at large may be discharged by the Commission of Insanity and provided for in the county institution.

Ohio.—A patient may be paroled for not more than 90 days with the consent and advice of the Board of Administration. The superintendent may discharge uncured patients except one with suicidal or homicidal tendencies. All recovered patients must be discharged.

Oklahoma.—Recovered patients may be discharged on the recommendation of the superintendent.

Oregon.—Recovered patients must be discharged, also other patients whenever the superintendent may think the best interests of the state institution require it. If a patient is discharged cured, all legal disabilities are removed.

Pennsylvania.—All persons restored to reason except the criminal insane are to be discharged. If the patient seems to be losing health under hospital treatment, any law judge upon application may investigate the matter and order a discharge.

Rhode Island.—Parole may be given for a period not exceeding six months. Unrecovered patients may be discharged upon the recommendation of the superintendent and trustees by an order from the Supreme Court. Persons who have placed an insane person in the hospital and have volunteered to assume temporary responsibility for his support may remove him.

South Dakota.—Cured patients must be discharged; uncured, harmless patients may be removed by their friends. Uncured, dangerous patients may be removed to the county of their residence by commissioners of insanity at the request of friends.

Tennessee.—Patients may be removed whenever in the judgment of the superintendent and the president of the board of trustees it is deemed judicious, proper and for the interests of the hospital, the patient and the community for them to leave the hospital. Private patients may be paroled for 30 days.

Texas.—All persons except those charged with or convicted of crime may be discharged by the trustees upon the recommendation of the superintendent.

Utah.—The judge of a court of record may return a patient upon satisfactory evidence that his friends will give him the proper care. A criminal patient charged with crime or convicted cannot be discharged unless by an order of a court having jurisdiction. Non-insane persons or one not judicially detained must be discharged by the court.

Vermont.—The board of supervisors of the insane may discharge any person, subject to revocation. The superintendent of the Brattleboro Retreat may parole a patient for 30 days. Persons who are recovered are discharged on the order of the supervisor with the consent of the superintendent.

Virginia.—The superintendent of the hospital may grant a parole for such time as may benefit the patient. When an insane person is restored to sanity he must be discharged. Any person not charged with crime or convicted of it may be discharged to the custody of friends, also one deemed harmless and incurable.

Washington.—Any person may be discharged when the superintendent deems it expedient.

West Virginia.—Any person in a hospital or jail who is restored to sanity must be discharged by the examining board. If in the hospital, by the circuit court; if in jail, by the circuit court or county court. Any insane person except one charged with crime or convicted of it may be delivered to any friend who will give a bond for his care. Harmless incurable insane persons may be delivered without bond to any friend able and willing to take care of them.

Wisconsin.—The superintendent of the state hospitals and of the Milwaukee County Hospital may parole a patient for a period of two years. If he can then no longer be at large with safety to the public, he may be returned without new proceedings. After two years the presumption of insanity ceases and he must be regarded sane. Harmless incurable insane must be discharged by the superintendent, to create room for more hopeful cases.

Wyoming.—No legal provision for parole or discharge of patients exists.

IV.

ADMISSION OF VOLUNTARY PATIENTS.

No section of any law seems more vague and lacking in uniformity than that governing the admission of voluntary patients to institutions for the insane, as now found in the statutes of the various states.

Out of the 48 states and the District of Columbia, the following 17 states and the District of Columbia already have provisions of law permitting the admission of voluntary patients, viz.: California, Colorado, Connecticut, District of Columbia, Illinois, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Wisconsin and Virginia.

California enacts that a person may be admitted voluntarily "who is suffering from mental disease, but is competent to make a written application." He cannot be retained more than seven days except upon legal proceedings required by considerations of safety.

In Colorado, a voluntary patient may be admitted "whose mental disease is not such as to render it legal to grant a certificate of insanity." If such person desires to leave the institution he must give three days' notice.

In Connecticut, a voluntary patient may be admitted "whose condition is not such as to render it legal to grant an order as to his insanity"; such person cannot be detained against his will more than three days.

In Illinois voluntary patients have been admitted to institutions since 1893. The law provides that "any person in the early stages of insanity who may desire the benefit of treatment in a state or licensed private hospital as a voluntary patient may be admitted on his own written application accompanied by a certificate from the county court stating that he is a private or county patient." Such patient, if admitted, shall have the same standing as any other private or county patient, provided that he has the right to leave the hospital at any time upon giving three days' notice to the superintendent.

During the biennial period of January 1, 1911, to December 31, 1912, voluntary patients were admitted as follows to the various institutions:

The Elgin State Hospital	30
Kankakee State Hospital	86
Anna State Hospital	21
Watertown State Hospital	144
Peoria State Hospital	118

The Chester State Hospital and the Chicago State Hospital had no voluntary patients.

In Cook County the lack of voluntary patients is ascribed to the fact that a former judge of the county court of Cook County did not approve of the law.

In Maryland, which seems to have had one of the earliest enactments on the subject, a voluntary patient "may be admitted who makes application in writing, provided the expense is borne by the person, his relatives or friends." He cannot be detained more than three days against his will.

In Massachusetts, the provision is simply that the "superintendent may receive any person as a voluntary patient who makes application and is mentally competent to make it." He cannot be detained against his will more than three days.

In Michigan there is a curious provision that voluntary patients "who are afflicted mentally or with serious nervous disability but who are not insane," must present certificates signed by two physicians having legal qualifications, "stating that the person needs asylum treatment, but is not insane." No provision exists for his discharge from the institution if he desires to go away. It is stated that if he is found insane he must have legal proceedings instituted to effect his regular admission.

In Minnesota, the provision is that any person believing himself to be afflicted with mental disease, upon written application signed in the presence of two witnesses not employees or officers of the institution, may be received into a detention hospital. If he demands his release and is deemed unsafe to be at large, he must be examined by the state hospital commission within three days and committed or discharged.

In New Jersey, "any resident of the state believing himself about to become insane and desiring to submit himself to treat-

ment," if he is competent to make an application, may be a voluntary patient. He must pay his own expenses and cannot be detained more than three days after giving notice.

In New York it is provided that "any suitable person who voluntarily makes written application" and is "competent to make it" may be admitted to a state hospital or licensed private institution. He cannot be detained more than 10 days against his will.

In Pennsylvania, persons who are threatened with mental disorders and voluntarily place themselves in institutions for the insane, may be received for a period of one month or less by an agreement which must specify the time and be signed by them at the time of admission.

In Ohio, "a person in an incipient stage of mental derangement may apply" and be received as a voluntary patient, but he cannot be kept more than 60 days.

Five voluntary patients only can be admitted to any one hospital and none can be admitted if the quota of the county is full. This seems to render the provision of very little practical benefit.

In Rhode Island, a voluntary patient is received into institutions "who is desirous of submitting himself to treatment and makes a written application, but whose mental condition is not such as to render it legal to grant a certificate of insanity." He cannot be detained against his will more than three days.

In Vermont any voluntary patient may be received "who seeks treatment and makes written application" for admission without certificates of physicians. He cannot be detained more than 48 hours against his will.

In Wisconsin, a voluntary patient who is "insane or suffering from mental disorders may, upon his written application, supported by certificates of at least two physicians, be admitted" to a state institution. He cannot be detained more than five days against his will.

In Virginia the law allows the superintendent to receive voluntary patients without legal commitment, when their reception will not crowd out patients who are committed by commissions appointed to ascertain their insanity. Voluntary patients are admitted by the superintendent, who fixes the rates and collects them. They are the only class of patients who pay for their treatment in the state institutions of Virginia.

It will be noticed that the phraseology of the different laws is vague and not always clear and that in some states it must be clearly shown by medical certificates *that the person is not insane* and yet is a fit subject for hospital treatment. In other states *the patient must be clearly insane* and his insanity must be shown by legal certificates. In others *the patient must be insane but not in such manner as to be certifiable by physicians.* Much of the confusion undoubtedly arises from the fact that, according to the decision of a number of appellate courts, the confinement of an insane person is not legal unless the person is dangerously insane either to himself or to the community. In several states unquestionably the reference to the insanity not being of such character as to be legally certified to has reference to this legal decision. In some states indigent patients can be admitted in this manner; in others provision is made that the expense of the voluntary patient shall be paid by himself or his friends.

In Michigan the original provision for the admission of voluntary patients provided that they should not be insane and that under no circumstances could they be supported by the state. A subsequent section of the law provided that voluntary patients could be cared for at the expense of the county and subsequently of the state, but the Attorney General declared it contradictory and invalid.

Among the earliest provisions is that of the State of Maryland. During the past five years a large number of other states have adopted the provision for the voluntary admission of patients. It is to be hoped that within the next five years all states may have a similar provision of law.

V.

CARE OF THE CRIMINAL INSANE.

The development of public opinion as to the care of insane criminals in the United States was a plant of slow growth.

As we have seen, in an early day in Maryland, Connecticut, Rhode Island and New York, little thought was given to the manifest inhumanity of attempting to care for the insane and still less to care for insane criminals in connection with the jail, house of correction or penitentiary; in fact many people believed that insane criminals were justly punished by imprisonment or even by hanging for crimes committed when manifestly insane.

In an early number of the *American Journal of Insanity* an account is given of the execution of an insane man in Connecticut, who had killed his wife under the delusion that she was a witch and went to execution with his mind wholly under the influence of his delusion and unable to appreciate that he was on the way to the gallows. There have been many instances where insane murderers have been confined in a state prison for life with no attempt to alleviate the hardships of prison life or to give them the care or treatment demanded by their condition. In many parts of the United States it has been customary in fact to dispose of imbeciles, often manifestly of the lowest grade of intellect and guilty of minor offenses because of a lack of reasoning power and manifest irresponsibility, by committing them to prisons or houses of correction. Some years ago an eminent alienist declared that he much preferred sending an insane criminal to a state prison than to an institution for the insane because he believed the discipline and severity of prison life more serviceable than the laxity of discipline inherent to the hospital treatment of the insane.

At the time the great wave of public interest in the insane spread over the country and state institutions were established, the predominant idea in the public mind was to provide a place where the curable insane could be cured. There was little thought for many years of making better provision for the chronic insane of any class, whether criminal or otherwise.

One of the first institutions for the criminal insane was established in connection with the state prison at Weathersfield, Conn., where, in an enclosure surrounded by a wall similar to that of the prison itself, the insane were to be cared for under the same conditions as to discipline, control and regimen as ordinary convicts. Through some freak in the legislative mind this building was never occupied and in 1859 was made a store-house for the penitentiary.

In New York, about 1850, a law was passed which provided for the transfer of insane criminals from the jails and prisons to the Utica State Hospital. The number of such transfers, however, became so great as to threaten to fill the hospital to its utmost capacity so that cases of acute disease for which it had been established could no longer be received. It was accordingly deemed advisable to establish at Auburn an asylum in connection with the state prison. This first asylum for insane criminals on a hospital basis was opened in 1855 and did excellent service until the increasing number of insane criminals required the establishment o a much larger institution at Matteawan. Even here the burden of caring for insane criminals, and especially for criminals who remained insane and required care after the expiration of their terms of sentence, became so great as to necessitate the establishment of another institution for the custody of insane criminals of the chronic class at Dannemora, in Northern New York, in proximity to the Clinton state prison. To-day, therefore, New York has two large hospitals for insane criminals.

In 1882, the State of Michigan established, in connection with the house of correction at Ionia, an institution for the criminal and dangerous insane, which has since been in successful operation. Recently it has been thought that its proximity to a house of correction interfered with its usefulness and it has been removed a distance of two or three miles from the house of correction, although still remaining at Ionia.

In Alabama the criminal insane are cared for separately in connection with the Tuscaloosa State Hospital. Upon recovery they are returned to prison.

In California a hospital for the chronic criminal insane is under construction at Folsom in connection with the state prison. Insane criminals may, however, be transferred to any one of the state hospitals for the insane.

In Colorado the State Hospital maintains a separate ward for the criminal insane.

In Connecticut an insane criminal is sent to the Connecticut Hospital at Middletown. If a person is acquitted of a criminal charge on the ground of insanity he must be committed to an asylum.

In the District of Columbia a separate ward is maintained at the Government hospital for insane criminals.

In Georgia insane convicts are kept and treated at the State Sanitarium.

In Illinois an institution for the dangerous insane is established at Chester.

In Indiana a hospital for insane criminals is established in connection with the state prison at Michigan City.

In Iowa a department for insane convicts exists at the penitentiary at Anamosa.

In Kansas a state asylum for the dangerous insane has been established in connection with the state penitentiary.

In Louisiana the State Hospital for the Insane has a ward for the criminal insane at Jackson.

In Maine an insane department for criminals is established in connection with the state prison at Thomaston.

In Massachusetts there is a large institution for the criminal and dangerous insane at Bridgewater.

In Minnesota a ward exists for the care of the criminal insane in connection with St. Peters State Hospital; there is also a department for insane criminals at the state prison at Stillwater. A separate institution for the criminal insane has been recommended by the State Board of Control.

In New Hampshire the criminal insane are committed to the New Hampshire State Hospital at Concord.

In New Jersey the state has under construction in connection with the Trenton State Hospital a house for the detention of convicts and insane criminals. At present they are cared for at the two state institutions, Morris Plains and Trenton.

In North Carolina there is a hospital for the dangerous insane at Raleigh.

In Ohio, a hospital for the dangerous and criminal insane is being constructed at Lima.[1]

[1] This hospital was opened for the reception of patients, February 15, 1915.

In Pennsylvania there is a hospital for the criminal insane at Farview, in the northeastern portion of the state.

In Rhode Island the criminal insane are sent to the prison insane ward at the State Hospital or to the state almshouse.

In Vermont a ward especially for the criminal insane is maintained at the State Hospital.

In Virginia there is a special ward for white criminal insane in connection with the Southwestern Hospital for the Insane at Marion and a similar department for the colored criminal insane at the Central State Hospital at Petersburg.

In Washington a department for the criminal insane exists in connection with the state penitentiary.

In the other states provision is made for the transfer of insane criminals to the state hospital for the insane.

CHAPTER X

IMMIGRATION AS A FACTOR IN THE INCREASE OF INSANITY

I.

IMMIGRATION AND THE CARE OF THE INSANE.

The introduction of discordant elements foreign to the established customs of the Anglo-Saxon population resident in the country and the consequent social and political unrest, mainly exemplified in the "American," or so-called early "Know Nothing Party," led Congress in 1838 to consider the necessity of the prevention of the introduction of undesirable persons into the United States from foreign countries, but no action was taken. At the same time the Judiciary Committee of the U. S. Senate recommended legislation prohibiting the entrance of idiots, lunatics and those suffering from incurable diseases or convicted of crime.

Finally in 1860 the practice of several continental governments in pardoning murderers with the provision that they emigrate to the United States, led to the adoption of a resolution of protest[1] and two years later a statute encouraging emigration was repealed. The continued agitation at last led to the Act of 1882, since which time immigration has been a subject of repeated legislation and wide discussion.

The first declaration on the subject of restrictive immigration legislation by the Association of Medical Superintendents of American Institutions for the Insane occurred at the thirty-eighth annual meeting of the Association in Philadelphia, in May, 1884.

It took the form of the following series of resolutions introduced by Dr. Foster Pratt of Kalamazoo, and finally, after a wide discussion, unanimously adopted:

WHEREAS, By a comparison of the statistics of the "defective classes" of our population, as shown by the eighth, ninth and tenth censuses, it appears:

First. That the proportion of insane to the total population in the United States is rapidly increasing; and

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[1] See "Growth of the Law of Insanity," chapter IX, page 325. Case of John Pastano.

Second. That a prominent factor in this increase is the large defective element found among the "foreign born" who have emigrated to us since 1847 and 1848, and who now constitute one-eighth of our total population, but who furnish, approximately, one-third of our criminals, one-third of our paupers, and one-third of our insane; and

WHEREAS, While the cost of buildings to suitably keep and the annual tax to properly maintain these classes falls wholly and heavily on the several states and territories, they are inhibited by federal laws from enacting and enforcing effective measures to prevent or mitigate these evils so far as they are caused by immigration; therefore,

Resolved, That the Association of Medical Superintendents of American Institutions for the Insane respectfully urge the Congress of the United States to give early and earnest attention to this important subject, to the end that immigration laws may be enacted by it which, while they do not unnecessarily obstruct the immigration of healthy and self-dependent persons, will effectively prevent the emigration and the exportation to our ports of the so-called "defective classes" of Europe and Asia.

Resolved, That in furtherance of the object, a copy of these resolutions and preamble be forwarded to the President of the United States and to the President of the Senate and the Speaker of the House of Representatives at Washington for consideration by them and by Congress; also to the Governor and presiding officers of the legislatures of each state in the Union, and to each State Medical Society, that they and the people they severally represent, who are most affected by the pecuniary burdens and by the physical and moral evils caused by the unrestricted and unregulated immigration, may be moved to take such steps as they deem best to secure early and efficient action by Congress (with whom alone is the power) to abate the great and growing evils to which public attention is hereby called.

In the discussion prior to the adoption of Dr. Pratt's resolutions it was indicated that it had been the practice of certain European countries to unload upon the American States the contents of their workhouses. It is true that the legislative enactment of August 3, 1882, charged the Secretary of the Treasury with the duty of supervising immigration and prohibited the landing of lunatics, idiots and persons liable to become a public charge. But the law was simply directory. The provisions for its execution were inadequate. There was no penalty imposed upon those who did not obey it. Hence further restrictions were suggested and finally put into adequate form by Chapter 551 of the Laws of 1891 (March 3).

This made it a misdemeanor to bring in any of the above prescribed classes and imposed a fine of one thousand dollars on anyone guilty of so doing. It provided, Section 11, that any alien

entering in violation of law could be returned at any time within one year thereafter, at the expense of the person or persons, vessels, transportation company or corporation responsible for his entry, and further, that those becoming public charges within one year from causes existing prior to landing should be considered as having entered in violation of law.

This statute continued in force unchanged until the act of March 3, 1903. This excluded idiots, imbeciles, feeble-minded persons, epileptics, and insane persons, persons insane within five years previous to landing, those having had two or more previous attacks at any time, paupers and all others liable to become a public charge. By Section 17 the officers of the United States Marine Hospital Service were charged with the duty of determining the mental condition of all immigrants. Section 20 provided that aliens coming to the United States in violation of law, who were found to be public charges from causes existing prior to landing, could be deported at any time within two years. Section 21 authorized the Secretary of Commerce and Labor to deport any alien within three years if entering in violation of law.

The amendment of February 20, 1907, Section 2, made mandatory the exclusion of idiots, imbeciles, the feeble-minded, epileptics, insane, all who had been insane during five years previous to landing, persons having had two or more attacks of insanity at any time, or who were likely to become a public charge, as well as individuals not comprehended in the foregoing excluded classes, but found to be suffering from mental or physical defects of such a nature as to affect their ability to earn a living.

Section 20 provided that an alien entering in violation of law or becoming a public charge from causes existing prior to landing should, upon the warrant of the Secretary of Commerce and Labor, be taken into custody and deported to the country from whence he came, at any time within three years after the date of his entry into the United States. The cost of the removal was to be a charge upon the owners of the vessel or transportation line immediately responsible. When the mental or physical condition of the alien was such as to require personal care or attention, the Secretary of Commerce and Labor was authorized to employ a suitable person for that purpose. The practical operation of the law was further provided for by rules and regulations to be formulated by the Com-

missioner General of Immigration. In cases becoming a public charge from prior causes, the application for deportation must be accompanied by

(a) An explicit statement that the alien is a public charge, where and how, and, if in an institution, the date of admission thereto.

(b) A full and accurate statement of the alien's disability, mental or physical; also whether or not a complete cure is possible, and if "yes" when, and if not, whether a partial cure may be expected, and to what extent the alien will thereafter be self-supporting. Also in insane cases, if recovered or apparently recovered from the attack, whether new attacks are to be expected.

(c) Whether or not the disability described constitutes the sole cause why the alien is a public charge; any other causes to be stated.

(d) Whether the causes which render the alien a public charge existed prior to landing, or arose subsequent thereto, and in the former case the reason in detail justifying such a conclusion.

At the sixty-eighth annual meeting of the American Medico-Psychological Association held at Atlantic City, N. J., May 28, 1912, the Committee on Immigration, Dr. Edward N. Brush, Chairman, submitted a series of resolutions in part as follows:

> That the entry of a large number of insane and mentally defective immigrants menaces the mental health of the country in this and succeeding generations, and by overtaxing the resources of our public institutions tends to produce lower standards of care, and that while the federal statutes provide for the exclusion of the insane and mentally defective immigrants, it would be more humane as well as more effective to reject such insane and mentally defective immigrants at the port of such entry, rather than wait until they and their families have established a residence in the country. And that it has been shown that the facilities for the mental examination of arriving immigrants are inadequate, and that the safeguards for the humane care of those deported are insufficient.

It was therefore recommended that the American Medico-Psychological Association should urge Congress to provide for mental examination of arriving immigrants by physicians in the United States Public Health and Marine Hospital Service, trained in the diagnosis of insanity and mental defect, and that adequate facilities be provided for the detention and examination of immigrants suspected of mental defects, and for the safe and humane return to their homes of those excluded.

Also that aliens who have been permitted entrance to the country and who become insane and show any mental defect within at least three years after landing, should be deported, unless it shall be shown conclusively that such insanity or mental defect has resulted from causes arising since the landing of said aliens, and that the question of such insanity or mental defect as well as of insanity, or mental defect in aliens seeking to land, should be authoritatively decided by physicians of experience and training in psychiatry.

Further, that the barbarous custom of deporting insane or mentally defective aliens without accompanying nurses or qualified attendants, of his or her own sex, and of experience in caring for such cases, is a reflection upon the intelligence and humanity of the country, and should at once be discouraged.

Also that the fine imposed upon transportation lines for bringing mentally defective immigrants into the country is inadequate and should be at least twice the amount now imposed, and that the same fine should be imposed for bringing insane immigrants into the country.

In the discussion, prior to the adoption of the committee's resolutions, especial stress was laid upon the deplorable lack of care meted out to the unfortunate deported insane alien during his passage to Europe, and the methods employed after landing to convey him to his former place of residence.

Until 1907 all insane immigrants were deported, without regard to their condition, by the first returning vessel available and aliens for whom warrants had been issued by the Department of Commerce and Labor were deported to the port at which they had embarked; their return to their own homes depending upon the humanity or good nature of the transportation companies.

Under these conditions many insane aliens were not reaching their homes, and complaints received led the New York State Charities Aid Association to investigate the matter. This investigation made it apparent that it was necessary some action should be taken, and accordingly the immigration law was amended at the instance of the State Charities Aid Association in 1907. The amendment provided that when the chief medical officer of a hospital or a medical officer of the Public Health or Marine Hospital Service certified that an insane alien was not in condition to attempt the journey alone, such insane alien should be accompanied by an

attendant. This was done for about six months when the steamship companies protested against the law on the ground that it was "too expensive."

A conference was then called by the authorities at Washington, the steamship companies and the State Charities Aid Association being represented.

At this conference it was decided that the intent of the law would be carried out by having a paper in four parts accompany deported persons. The first part of this paper was to be signed by the Commissioner of Immigration, stating the alien's condition. The second part was to be an acknowledgment on the part of the transportation company of the receipt of the alien. The third was to be a statement of the master of the vessel regarding the care given on the voyage and a receipt by the European forwarding agent. The fourth part was to be signed by the relatives of the alien or the proper authorities acknowledging the receipt of the alien in his home.

It soon became apparent that old conditions were returning, however, and it was proposed that the law be changed, so that the Secretary of Commerce and Labor should be obliged to provide competent attendants when needed and that the expense should be borne by the government.

On June 28, 1912, a conference was held between Mr. Edward B. Sanford, attorney, representing the steamship companies, Mr. Goodwin Brown and Dr. George S. Campbell, representing the State Hospital Commission of New York, and former Congressman William S. Bennett, at which the following agreement was made concerning the deportation of some two thousand alien insane then in the New York State hospitals:

The steamship companies agreed to take the alien insane at the ordinary steerage rate if they are notified before sailing of the patient's condition and assured that he is not dangerous. The commission will turn over to each of the lines the patients who came to this country by that line and will furnish information as to the identity and place of destination of each alien. The passage money is to be paid by the state. It was estimated that from six months to a year would be required to deport the whole number.

At the 69th annual meeting of the American Medico-Psychological Association held at Niagara Falls, Canada, June 10, 1913,

the Committee on Immigration reported that immigration bills, containing four of the six recommendations made by the committee, had been passed by both houses of Congress. Other provisions in these bills, notably a literacy test, unfortunately resulted in their veto by President Taft. The recommendations of the committee, however, received the strong approval of the President, who stated in his veto message he regretted that it was impossible to sign a bill carrying these excellent provisions.

The committee further stated that bills had been introduced in the Senate by Senators Dillingham and Overman and in the House of Representatives by Mr. Roddenbury, which embodied all the recommendations of the committee.[1] As the whole matter was still undecided, a motion to continue the Committee on Immigration was unanimously carried.

[1] Nothing further has been accomplished as regards the passage of the revised Immigration bill, as recommended by the Committee on Immigration of the American Medico-Psychological Association. Principally by reason of a literacy test, the bill met the fate of its predecessor, and was vetoed by President Wilson.

II.

THE ALIEN-BORN IN RELATION TO THE COST OF STATE CARE.

The State of New York has been more interested in the question of the alien insane in the state hospitals than any other state. This is by reason of the fact that the port of New York receives at least eight-tenths of all the immigrants coming to this country, while about 26 per cent of the total become residents of the State of New York. It can therefore be safely stated that conditions existing in New York, while extreme, are nevertheless representative of conditions existing in other parts of the country, and will serve to show the question at issue in the clearest possible light.

As far back as 1847 the State of New York created a commission of emigration, whose duty it was to properly safeguard and help to employment all the immigrants arriving at the port of New York for a period of five years after their arrival, the funds for which purpose being created by a small commutation payment by each immigrant. Between the years 1847 and 1855 this state emigration commission paid to the State of New York $2,250,000 as the state's share of the cost of the support of those aliens who within five years had become a public charge.[1]

In 1890 there were 16,006 insane in the various institutions under the State Commission in Lunacy, and 23,778 in 1900, an increase of 48.05 per cent. On December 31, 1903, there were 11,611 foreign-born patients in the New York State hospitals for the insane. In addition there were on that date 4025 patients of foreign parentage and 874 of mixed parentage, only 55.4 per cent of the patients in the public and private institutions of the state at that time being of native parentage.

In 1910 the total number of patients reported under care was 32,658, or 37 per cent more than in 1900, with a growth of population amounting to 25 per cent during the same period. In February, 1912, there were 31,432 patients in the fourteen state hospitals, 41.09 per cent of whom were of foreign birth.

[1] Speech of Hon. Lathrop Brown, of New York, in the House of Representatives, January 30, 1914.

During the year ending September 30, 1911, the state disbursed approximately $7,378,000 for the care of the insane. It will readily be seen that a large proportion of this expenditure is made necessary by providing for the maintenance of aliens.[1]

During the year 1904 an act was passed by the State Legislature amending the insanity law and providing for the examination of immigrants at the port of New York to ascertain their mental condition. Provision was made in Section 18 of this act for the establishment of a board of alienists for the examination of the insane, idiotic, imbecile, and epileptic immigrants, such board to consist of a chief examiner and two assistant examiners to be appointed by the State Commission in Lunacy. This board was required to inspect and examine immigrants coming into this country at the port of New York, for the purpose of determining whether they came within the above mentioned classes. It was also the duty of the Board of Alienists to notify the State Commission in Lunacy of the location of all insane patients who were non-residents of the State of New York, the board receiving the necessary authority from the commission in all suitable cases for the investigation and removal of all such cases. The board was directed to notify the proper authorities of the United States having control of the enforcement of the immigration laws at such port and arrange for the deportation of such alien insane in accordance with the provisions of the federal enactment.

In 1906 the board was officially recognized by the federal government, and an invitation was extended by the authorities of Ellis Island "To witness at the pleasure of the board the medical examination of immigrants with special consideration for their mental condition, and if any case should come to their notice after having passed these surgeons, the government would be pleased to have their attention called to the matter, when the case would be re-examined."

The board has arranged for the deportation of insane aliens who had been admitted to the various state hospitals as well as to the observation wards at Bellevue and Kings County hospitals. As a result of the activities of the board during the seven years ending September 30, 1911, it investigated 6910 cases of alien and non-

[1] "Immigration and the Insane in the State of New York," James V. May, M. D., New York State Hospitals Bulletin, April, 1912.

resident insane and of this number 3718 were removed from the state. This represents an approximate saving on maintenance, based on the per capita cost of caring for the insane, of practically $685,490 during the years 1905-1911. If the cost of construction, etc., is included, the total saving as a result of the removals of these aliens and non-residents is approximately estimated at $3,251,390. This saving has been effected at a total cost of $211,600, this amount representing the total expenditures of the Board of Alienists during that time. When the fact is considered that the approximate per capita cost of caring for the insane at the present time is $190 per annum, and the estimated average hospital life of each insane person is about nine years, the magnitude of the expenditures required for his support will be readily appreciated.[1]

The study made by the Federal Census Bureau in 1904 showed that the relative frequency of insanity among the foreign born in the various states differed in accordance with the nationalities composing the foreign-born population. Taking the country as a whole, however, the foreign born, which in 1900 formed only 19.5 per cent of the total population 10 years of age and over, contributed 34.3 per cent of the insane.

Of the 5700 first admissions to the fourteen state hospitals of New York for the year ending September 30, 1911, only 1224, or 21.47 per cent, were native born of native parentage, while 1481 were native born of foreign or mixed parentage. No less than 4218 patients were either foreign born or children of parents one or both of whom were foreign born. Taking the two generations into consideration, the foreign element contributed 74 per cent of the first admissions.

Comparing the percentages of nativity among the first admissions with the percentages among the general population, we find that the native-born population, which constituted 70.1 per cent of the whole, contributes 51.28 per cent of the first admissions, while the foreign-born population, which constitutes 29.9 per cent of the whole, contributes 48.02 per cent of the first admissions. The frequency of insanity among the foreign born throughout the states is therefore 2.19 times as great as among the native born.

[1] Communication from the State Commission in Lunacy to Hon. John A. Dix, Governor of the State of New York, February 27, 1912.

The rate of insanity among the total foreign born in New York City is 2.48 times that of the native born.

Of the 1560 re-admissions for the year ending September 30, 1911, 984, or 63.1 per cent, were native born and 573, or 36.8 per cent, were foreign born, while the birthplace of three patients could not be ascertained. Both parents of only 496 patients, or 31.8 per cent, of the whole number of re-admissions were native born. Of the 806 who were residents of New York City at the time of admission, 416, or 51.6 per cent, were foreign born. Both parents of only 100, or 12.4 per cent, of the New York City re-admissions were native born.[1]

The data of the federal census of 1910 concerning the nativity of the foreign-born insane in institutions in the United States are not available, but taking the figures from the federal census report of 1904, we find that in that year there were in all institutions (civil, criminal and private) in the United States 47,078 foreign-born insane patients.

In 1912 the New York State Hospital Commission estimated the net cost for each alien patient for that year to be $279.18. On this basis the net cost to New York State for 1912 of its 9241 alien insane would be $2,579,902.38.[2]

The fundamental reason for the existence of the problem of the alien insane is the helpless position of the states, under the present law, as to the admission and expulsion of aliens.

The state has no jurisdiction over immigration, other than that incident to the exercise of its police power, and has neither the right to prevent undesirable aliens from coming within its borders, nor authority to remove them therefrom once they have entered. The power to regulate immigration is vested in the federal government alone, which by its laws and rules determines what aliens shall be admitted to or removed from the several states.

The states must therefore receive within their borders all such aliens as the United States may admit thereto, and must apply to

[1] "A Statistical Study of the Foreign-Born Insane in the New York State Hospitals," by Horatio M. Pollock, New York State Hospitals Bulletin, April, 1912.

[2] "Report of the Alien Insane in the Civil Hospitals of New York State," Albany, N. Y., 1914.

the federal authorities to remove therefrom any aliens found to be undesirable.

Although it takes five years for an alien to become a citizen, nevertheless an alien by being three years within a state, neither desiring nor intending to become a citizen, at no time contributing by the payment of direct taxes to the support of the commonwealth and being unavailable for the military or civil duties of a citizen, may, if he becomes insane, by operation of the Immigration Act, acquire such rights as against the state that it is powerless to expel him from its boundaries or to compel his return to the country of which he is a citizen, but, for its public safety and welfare or from humanitarian motives, must care for and maintain him so long as he chooses to remain.

It would seem, however, that but few of the states fully realize the importance of deportation and the saving resulting therefrom, for the report of the Bureau of Deportation for 1913 states that during the 12 months ending September 30, 1913, the total number of insane aliens deported from all ports of the United States upon federal warrant as being insane from causes existing prior to landing numbered 641; that of those 379, or 59.12 per cent, were deported from New York State, leaving 262, or 41.88 per cent, as representing the efforts of all the remaining states. According to the figures of the census of 1910 New York State had 16.7 per cent of the insane in institutions in the United States, while in 1904, the last year of which the figures are available, New York was caring for 25.2 per cent of the foreign-born insane.[1]

As of interest in this connection we have appended herewith a statement of the number deported to other states and countries by the Massachusetts State Board of Insanity since its establishment in 1898, giving this information by years. In addition, figures showing the number deported by the United States Commissioner of Immigration from institutions under the supervision of the Massachusetts State Board of Insanity since 1904, the first year the figures were published, are given.

[1] *Ibid.*

DEPORTATIONS FROM MASSACHUSETTS TO OTHER STATES AND TO FOREIGN COUNTRIES.

Year.	By State Board of Insanity. Other States.	Other Countries.	Total.	By United States Commissioner of Immigration.
1899	41	84	125	..
1900	50	79	129	..
1901	56	84	140	..
1902	36	60	96	..
1903	45	82	127	..
1904	36	61	97	30
1905	60	63	123	45
1906	50	79	129	43
1907	55	60	115	60
1908	58	43	101	73
1909	55	96	151	84
1910	63	79	142	82
1911	49	54	103	62
1912	66	66	132	84
1913	69	96	165	109
Total	789	1086	1875	672

There is also appended the following extracts from biennial report of the deportation agent of the State Board of Control of Minnesota for the period ending July 31, 1914:

DEPORTATIONS.

During the year ending July 31, 1913	77
During the year ending July 31, 1914	143

DESTINATION OF DEPORTED PATIENTS.

	1913	1914
Austria	..	4
Belgium	..	2
Canada	3	7
Denmark	1	..
England	1	1
Finland	2	4
France	1	..
Germany	1	..
Holland	..	2
Hungary	1	..
Italy	1	3
Norway	2	7
Russia	1	2
Scotland	..	1
Sweden	4	3
Switzerland	2	..
Other states	57	107
	77	143

During the same period the United States deported 33 cases, without expense to the state except cost of maintenance pending deportation.

There was expended by the state during the period the sum of $7755.06; this amount divided by the number of deportations made by the state gives a per capita cost of deportations of $41.47.

Improved reciprocal relations with contiguous states have been in part responsible for these results.

CHAPTER XI

INSANITY AMONG NEGROES, INDIANS, CHINESE AND JAPANESE IN THE UNITED STATES

I.

INSANITY AMONG THE NEGROES.

In Volume I, of the *Journal of Insanity,* pages 287-288, occurs the following note:

"Insanity is rare we believe among Africans. Cinquery and others of the Amistad negroes, when in this country a few years since, visited the Retreat for the Insane at Hartford, Conn., and saw many of the patients there. They informed the writer of this article that insanity was very rare in their native country. Most of them had never seen an instance. Cinquery stated, however, that he had seen one case."

Whatever might be the prevalence of insanity among the negroes in Africa, it was very early recognized among their descendants in this country, as is shown by the records of South Carolina, which contain in an act for the relief of the poor, enacted in 1751, a section "providing for the subsistence of slaves who may become lunaticks while belonging to persons too poor to care for them." By this section justices of the peace and overseers of the poor are required upon notice "to cause such lunatic slaves to be secured in some convenient place in the parish, as well as to prevent their doing mischief, and for the better subsisting of such lunatic slaves, the expense to be borne by the parish."

Again it is found that at a meeting of the court of directors of the Hospital for the Insane at Williamsburg, Va., held on April 19, 1774, Charity, a free mulatto woman, brought to the hospital from the County of Richmond, was found to be a person of insane and disordered mind, and it was ordered that she be received into the hospital.

This hospital was the first in America to care for the colored insane.

In the History of the Western State Hospital for the Insane at Staunton, Va., published in full in a subsequent volume, it is stated that from its opening in July 1828, "No distinction of race was made among those who partook of the charity of the state. In the case of white or black, rich or poor, the only plea to be made was that of need."

At first there seem to have been no complications or difficulties arising from the mingling of the races. In 1848, however, when the asylum was enlarged we find that the court of directors placed itself on record as follows:

"That owing to the construction of the buildings here, it would be utterly impracticable to make suitable provision therein for the accommodation of colored patients; and were it practicable we should deem it highly inexpedient that the two classes of unfortunates be placed within one and the same enclosure."

As a result of this recommendation, the General Assembly of Virginia passed an act on January 22, 1850, appropriating $11,500 to provide free accommodations for insane negroes at Williamsburg. Prior to this, in 1846, the General Assembly had passed a bill permitting insane slaves to be received in the Williamsburg Asylum, but only when there was sufficient room after the white insane had been provided for.[1]

About the same period, the South Carolina Legislature passed an ordinance, December 19, 1848, entitled "An Act to Authorize the Admission of Persons of Color Into the Lunatic Asylum."

It is of interest to note that the first patient received into the Eastern Lunatic Asylum at Lexington, Ky., which was opened on May 1, 1824, was "a colored woman named Charity, aged 21, who had never been able to walk or talk, nor had she ever partaken of solid food."

It is very evident from the above examples that insanity existed among the negroes in the Southern states prior to emancipation, and that in some states at least legislative relief was granted to them. With the exception of the specific Act of 1751 in South Carolina, the care offered in most cases applies only to free negroes, the masters being supposed to care for their mentally infirm slaves. No doubt some of the negroes admitted to the Wil-

[1] In 1855-56 a special building was built for the colored insane at the Government Hospital, Washington, D. C., which the superintendent stated was the "first and only special provision for the suitable care of the African when afflicted with insanity which has yet been made in any part of the world." This was not the case, however, for in 1853 the colored insane of Virginia were being cared for in a separate building at the Eastern Asylum, at Williamsburg. (See "History of the Central State Hospital, Virginia," by W. F. Drewry, M. D., in a subsequent volume.)

liamsburg Asylum were slaves whose maintenance was paid for by their masters, but in most cases it seems certain that the insane slaves were cared for on their own plantations, where the cost of their maintenance could be reduced to a minimum.

The subject of mental affections among the negroes, owing to the rather wide-spread belief that such disorders have rapidly increased since their emancipation, has been given of late years a great deal of attention.

Dr. William F. Drewry, superintendent of the Central State Hospital, Petersburg, Va., in a paper on the "Care and Condition of the Insane in Virginia,"[1] gives a series of reasons to account for the causes which have operated with such disastrous results to the negro's mind since his emancipation. Briefly stated they are as follows:

1. During slavery there were doubtless many mildly insane and weak-minded and senile negroes, who were cared for by their owners and never reported. In those days the census reports were very imperfect.

Old inhabitants tell us that before the '60's an insane negro was a rarity, and the facts all go to show that the disease was by no means prevalent among the race. The regular, simple life, the freedom from dissipation and excitement, steady and healthful employment, enforced self-restraint, the freedom from care and responsibility, the plain, wholesome, nourishing food, comfortable clothing, the open-air life upon the plantation, the kindly care and treatment when sick, in those days, all acted as preventive measures against mental breakdown in the negro.

2. The negro, as a race, after the war was not prepared to care for himself or to combat the new problems in his life. He became a prey to his own weaknesses and passions and to whatever constitutional deficiencies he had. He suffered from ignorance and disregard of hygienic laws, promiscuous over-crowding in living quarters, and laxness in the bonds of the family circle. Habits of indolence, intemperance, immorality; often insufficient and unwholesome, cheap and adulterated food and whiskey, have all operated against the physical and mental welfare of the negro.

[1] Read at the 35th National Conference of Charities and Correction, Richmond, Va., May, 1908.

And in recent years he has become, in a large measure, a victim to cocaine and other drug habits.

3. Hereditary deficiencies and unchecked constitutional diseases and defects, with their direful influences, transmitted from parent to offspring, with an almost desperate disregard of consequences, play now a hazardous part in the causation of insanity and epilepsy in the race. It has only been in recent years that hereditary influences have been a significant factor.

4. A better understanding now than formerly of the nature of insanity, a more general knowledge and appreciation of the benefits derived from hospital care and treatment, and an increased confidence in the humane methods usually in vogue, tend to increase the number of commitments in the negro race as well as the white.

5. The crowding in unsanitary hovels in cities, idleness and irregular habits have had tremendous effect in undermining the health of the negro and making him an easy subject to mental disease.

6. A willingness and even desire on the part of many negroes nowadays to shift from themselves to the state the burden of the care of those who are weak-minded or senile or dotard; and the simplicity of present medico-judicial methods of commitment, as compared with former complicated judicial procedures, which were not unlike a trial for a criminal offense, also help to account for the increased number of patients in our hospitals.

7. The regular life and constant care and treatment of the chronic insane in a hospital tend to prolong life, and thus cause an ever increasing accumulation of chronic incurable cases, who are a charge ever afterwards upon the state.

It is fact worthy of observation that the greater number of insane negroes come from the uneducated, thriftless classes and from the old and decrepit; comparatively few patients come from the educated and more prosperous classes. A well nourished, intelligent, thrifty negro, leading a correct life, is probably little more liable to become insane than a white person under similar conditions, except for the fact that the powers of resistance and endurance are weaker in his race than in the white race. In short, the negro is to-day an easier prey to constitutional diseases than the whites and succumbs more readily to strain, stress and disease.

According to a paper on "Psychoses Among Negroes—A Comparative Study,"[1] by E. M. Green, M. D., Clinical Director Georgia State Sanitarium, Milledgeville, Ga., at the beginning of the year 1870, 380 patients were confined in his institution, of whom 321 were white and 59 were colored. During the succeeding ten years the proportion of negroes increased more rapidly than did the whites, and in 1880 the ratio between the races was one to four. In 1900 a ratio of 1 to 2.2 was reached, and this has remained practically stationary since that time.

Dr. Green finds that certain psychoses appear more often in one race than in the other and states that "at the outset we must recognize that in every consideration of the negro race we are dealing with two distinct classes, one composed of those of mixed blood and the other of pure or comparatively pure blood."

In the *psychoses accompanying pellagra* he finds that "it is probable that admissions to a hospital for the insane do not accurately number the cases of mental disorder associated with pellagra. The most prominent manifestations of such disorders are a delirious state, a period of clouded consciousness with hallucinations and apprehensiveness, and active delirium which necessitates constant care. Under such conditions the patient cannot be kept at home unless his relatives are able to provide the necessary care and treatment. The negro as a rule, being unable to supply either, is compelled to have the patient committed to a hospital where he can be cared for without cost."

Dr. Green gives a table showing the forms of psychoses found in 2119 negroes admitted. In view of the generally accepted opinion regarding the use of liquor and drugs by the negro race this table is of great interest. It shows that alcoholic psychoses are found three times as often in the white as in the negro, and that of the cases admitted during a period of five years, only six negroes have suffered from drug psychoses, as opposed to 142 such cases occurring in the white. As regards the statements made as to the enormous increase in the use of cocaine by the negro, he states that in 2119 cases, cocaine addiction appeared once alone, and once in combination with other drugs as an etiological factor in psychoses. He explains these figures by the fact that very few negroes earn more than enough to furnish their bare necessities.

[1] Journal of Nervous and Mental Disease, Vol. XLI, No. 11, Nov., 1914.

and that the cost of alcoholics to enable them to indulge their appetite over a protracted period, is prohibitive; and it is upon the basis of chronic alcoholism that the alcoholic psychoses develop. In the case of cocaine, the habitual use of the drug unfits the individual for work and when work ceases money to purchase the drug fails, so that the habit does not become established.

In the white race even the high grade imbecile sooner or later finds his way to an institution where his talents may be put to the best advantage, but in the negro a moderate mental defect is apt to be less noticeable. As a rule the true condition is not appreciated until an episode of some kind renders commitment necessary. For these reasons the number of negro patients assigned to the *imbecility* and *idiocy* group is smaller than the white.

It must be remembered that the negro is of a simple nature, giving little thought to the future, accepting responsibility thoughtlessly, and desiring only the gratification of the present. He is easily roused to happiness, and his unhappiness is transitory, disappearing as a child's when other interests attract his attention. Suicide, though not unknown, is an extremely rare occurrence in the negro race. He is seldom depressed, and finds pleasure from occasions which would give rise to sadness in the whites. He is superstitious, and believes in ghosts, witches, spells, poisons and conjuring. Towards members of his own race he is suspicious, fearing bodily harm, and attributes any misfortune or sickness to the effects of witchcraft. From childhood he is threatened with beasts, spooks and witches, and the chief subjects of the conversations he hears are of ghosts and conjuring. He is early familiar with the meaning of signs, and the various acts by which he may escape bad luck. When he reaches the age of puberty, and ideas of love and sexual gratification come into consideration, the influence of charms and of herbs is resorted to to bring his desires to fruition. To quote from Dr. Green:

"The fear of the supernatural, the suspicions of his fellows and the necessity of guarding at all times against bad luck and the machinations of enemies, play a part in bringing about psychoses which more frequently than in the white takes the form of dementia præcox."

Dr. Green further adds that "the discrepancy between the ratio of manic depressive psychoses in the two races is still more strik-

ing than in dementia præcox. The negro race is emotional; in grief noisy and obtrusive, it is of a superficial character and soon passes; in happiness active, boisterous, restless, manifesting increased muscular activity, it is aroused with little provocation and reaction to it is excessive. Slight pleasure causes exaggerated evidence of elation. We have seen that the manic forms of the psychosis occur in a much larger proportion to the depressive forms than is the case with the white race, and this is only what we should expect to find in a race whose characteristics are such as have been enumerated above."

In the Northern and Western states, where racial antipathy is at a minimum, and where the negro forms a small ratio of the general population, no special provision is necessary for his care in hospitals for the insane. In the South, however, a very different condition prevails. In this region it seems to be the unanimous opinion of the authorities that the separation of the white and colored patients is to the advantage of both races. According to Powell,[1] "the distinction has been made for social reasons alone. Consequently we find to-day in most Southern asylums four departments, whereas in other institutions two suffice."

Three states, Maryland, Virginia and North Carolina, have separate hospitals devoted to the care of the colored insane exclusively. And one state, Alabama, has a separate hospital for their care but under the same management as the hospital for white patients. Most of the states, however, care for their negro insane in separate departments of the hospitals devoted to the care of the white insane as well. This is the older custom which was in force from the beginning of institutional care of the insane in the Southern states.

In Virginia, the colored insane were cared for in the Eastern Lunatic Asylum at Williamsburg until December 17, 1869. On that date, at the suggestion of Dr. Stribling, and by order of Major-General Canby, Military Commander, an asylum for the colored insane of the state was established near Richmond. This hospital, known as Howard's Grove Asylum, was the first institution in America to be devoted to the care of the negro insane exclusively. This institution was finally located at Petersburg, and opened for the admission of patients in April, 1885. It is now

[1] Transactions American Medico-Psychological Association, Vol. 4, p. 125.

known as the Central State Hospital, Petersburg. In 1911 there was constructed at this institution a building exclusively for the colored criminal insane. The Eastern Asylum for the Colored Insane, Goldsboro, N. C., was the second hospital to be devoted to the colored insane exclusively, being provided for by the North Carolina Legislature of 1875, and opened for the reception of patients on August 1, 1880.

The Hospital for the Negro Insane of Maryland was established by act of the General Assembly of Maryland on April 11, 1910, which made an appropriation of $100,000 for the purchase of land and the erection of buildings. On December 13, 1910, a site was purchased at Crownsville, Anne Arundel County, and temporary buildings were erected for the admission of patients. On July 21, 1911, 16 patients were admitted.

We have already seen that South Carolina, by an ordinance of December 19, 1848, authorized the admission of persons of color into the "Lunatic Asylum." In a report to the regents of the same institution, in 1869, we find Dr. Parker, the superintendent, urging better provision for persons of color. He states that until the close of the war the number in the asylum never exceeded five, but that during the year 1869 the number admitted was 29, and that the buildings appropriated exclusively for their care were almost full. He recommended that a separate building of brick, properly planned and arranged, be erected as soon as possible for the exclusive use of the negro insane.

There seems to have been recommendations to the same effect made annually by successive boards of regents and superintendents, but such a building was not erected until 1897.

This building, a three story brick structure, was used for the accommodation of the negro males. The females were housed in the old asylum building, the original structure built in 1822.

In 1866 the Legislature of Georgia appropriated $11,000 for an insane asylum for negroes, and the building was located on the grounds of the asylum for the whites. In 1870 the Legislature appropriated $18,000 for the enlargement of this building, and in 1879, $25,000 for the same purpose.

In 1881 an appropriation of $82,166 for a new building was made. These several enlargements provided for 541 negroes. In

1893 the Legislature appropriated $100,000 for the erection of additional buildings for the white and colored insane.

In Louisiana negro patients are received at the Louisiana Hospital for the Insane, Pineville, under the same circumstances and are given the same treatment as white patients. They are, however, domiciled in separate buildings.

In Alabama a few negro patients are cared for in "The Bryce Hospital." The Mt. Vernon Hospital, 56 miles distant from the "Bryce Hospital," is devoted exclusively to the care of negroes. An exceptional feature in the Alabama hospitals is they are under the same management, one superintendent acting for both hospitals, but with an assistant physician at each hospital.

The Mt. Vernon Hospital was provided for by the Legislature of 1900-01. Most of the buildings have been built by hospital employees, and are one story cottages, no one of which holds more than 150 patients.

In Florida the negro insane are cared for in special buildings at the Florida Hospital for the Insane, Chattahoochee.

In Mississippi the negroes are cared for in separate buildings at the State Insane Hospital at Asylum.

In Tennessee there is a detached building, erected in 1895, at the Eastern Hospital for the Insane at Knoxville, to care for the negro insane of East Tennessee. A similar building was built in 1868 at the Central Hospital for the Insane at Nashville. At the Western Hospital for Insane, at Bolivar, the negro patients are accommodated in a separate wing of the main building.

The Western State Hospital, at Hopkinsville, Ky., has separate buildings for the colored male and female patients.

In West Virginia the colored insane are cared for in a special building at Weston.

According to a paper on "Psychosis in the Colored Race,"[1] by Mary O'Malley, M. D., "the census of 1860 shows that there was a total of 766 insane colored patients in institutions in the United States in a population of 4,031,830, and the census of 1910 shows a total of 13,567 insane colored patients in institutions in the United States in a population of 9,827,733. From 1860 to 1910 the colored population increased 111 per cent, and in the same time the number of colored insane increased 1670 per cent."

[1] The American Journal of Insanity, Volume LXXI, page 309.

According to the census of 1910, the ratio for the insane per 100,000 population, is, outside the South, higher for negroes than for whites in every geographic division. In New England, for instance, the ratio is 105.9 per 100,000 whites, as compared with 153.8 per 100,000 for negroes, and in the Middle Atlantic division the ratios are 75.3 per 100,000 and 105.1 per 100,000 respectively. In the South Atlantic division, on the other hand, 59.7 out of 100,000 whites were admitted to insane asylums, as compared to 46.2 out of 100,000 negroes. In the East South Central division the number of admissions per 100,000 population was 47.5 for the whites and 35.8 for negroes; and in the West South Central division it was 38.8 and 17.3 respectively. There are some individual Southern states, however, in which, as in the North, the ratio of admissions to hospitals for the insane is higher for negroes than for whites. These states are Delaware, Virginia, West Virginia, Florida, Kentucky and Tennessee.

II.

INSANITY AMONG THE NORTH AMERICAN INDIANS.

In Volume I of the *Journal of Insanity*, upon page 287, occurs the following note:

"Dr. Lillybridge of Virginia, who was employed by the government to superintend the removal of the Cherokee Indians in 1827-8-9, and who saw more than 20,000 Indians and inquired much about their diseases, informs us he never saw or heard of a case of insanity among them."

"Dr. Butler, who has been a devoted missionary and physician among the Cherokees for about a quarter of a century, informs us in a recent letter that he has as yet seen no case of decided insanity among them, though he has occasionally seen them delirious when sick of other diseases; and adds that an intelligent chief, a man now 80 years old, told him that "he had never known a case of insanity among his people, such as he had seen in the hospital at Philadelphia."

In the early settlement of the country the Indians were in a sense segregated, and did not come into very close contact with their superior, the white race. Accustomed to their old traditions they kept their own counsel, and if any one of their number became insane they either secluded him or managed to take care of him without outside interference. It was usual for them to attribute the origin of insanity to the action of some evil charm, or the administration of some noxious potion, obtained by an enemy from one of the many "medicine men." There was also an implicit belief that if a counter-remedy or charm could be procured from a "medicine man" having greater power than the one from whom the injurious charm had been derived, the patient could be quickly cured.

Cases of acute mania, especially if violent, were supposed to be possessed by a cannibal spirit, or *windigo*, and being thus a menace to other members of the tribe were promptly shot or otherwise disposed of without ceremony.

In a paper on "Witchcraft in Certain Legal and Medical Relations," Dr. C. B. Burr recounts the following:

"A venerable priest ministering to the necessities of the members of a fast disappearing tribe of Indians, in the lower St. Lawrence, told me of unique methods in vogue among them for overcoming the evil spirit '*windigo*,' supposed to possess the body of one insane and to eat out the souls of others. It was the aim of the Indians to lose in the woods or otherwise dispose of one afflicted with a mental infirmity. On one occasion the priest heard by chance of a puerperal woman suffering from mania. Approaching her cabin about which many "braves" were standing, he heard the words "the cure is coming." The reason for the warning was soon apparent. Inside the cabin he discovered the woman bound to a chair, placed back up and in a sloping position. Round her neck was a cord which extended through a chink in the rear wall of the cabin. At the other end of this cord there had been relays of Indians, who made it taut from time to time. The priest extricated the squaw from her perilous position, soothed and cared for her."

From an extract furnished by Dr. T. J. W. Burgess, from "A Narrative of the Adventures and Sufferings of John R. Jewitt, Only Survivor of the Crew of the Ship Boston, During a Captivity of Nearly Three Years Among the Savages of Nootka Sound," an interesting account is given of a case of insanity as regarded by the Indians at that time. As a matter of interest to those to whom a copy of Jewitt's story is not accessible, a synopsis of the extract is given in an Appendix, on page 393.

Dr. Burgess states that "from information derived from Professor Hill-Tout, Judge Howay of New Westminster, British Columbia, and others, it would seem that the Indians looked upon insanity as they did any other sickness. It was simply the "bad medicine" which some enemy had caused to affect him. Its comparative rarity is shown by the fact that they had no conception of how to treat it. Many things, however, go to show that the Indians were well enough acquainted with insanity to regard unusual conduct as a proof of its existence. For example, they regarded the famous botanist, David Douglas, who did so much work on the Pacific Coast, as weak in the head. Nor is it at all unnatural that, seeing a man roaming about the country in all directions to gather plants, mosses, lichens, seeds and insects, whereas they were wont at that time, 1827-1833, to see men hunting

fur-bearing animals only, they should regard him as not quite right mentally, and so designate him the "grass man."[1]

The story of Mark Jack, an insane Indian of the Tuscarora tribe, who was under treatment at the Utica State Hospital from 1851 to 1874 and at the Willard State Hospital from 1874 until his death there eight years later, is of interest, because it seems to show that insanity among Indians follows much the same course as among white persons.

He was a farmer of common school education, but considered one of the most intelligent men of his tribe, of temperate habits and a church member. A maternal uncle was an imbecile and a maternal aunt was "singular"—a half-brother by his mother's former husband was insane. He first showed insanity at the age of 22 years, at a time when he was attempting to learn English and to study mathematics in 1843, and for two years he had periods of excitement, followed by intervals of quiet in which he was able to do farm work. About the third year he became so violent and incoherent in his talk as to require to be kept in close confinement in a log hut, and remained there for six years. His excitement was called by his Indian associates "*conreaya bonos*," or madness. Being a ward of the state, he was admitted on the order of Governor Washington Hunt. At the time of his admission his brother stated that two other members of the same tribe had been insane, one of whom recovered and the other died. His condition during the 31 years of institutional treatment was one mostly of quiet dementia, with rare intervals of noisy excitement. His habits became untidy and eventually convulsive seizures developed. He was probably in a stage of terminal dementia at the time of his admission to the hospital at Utica. It is evident that he had a strong hereditary tendency to insanity which was developed by his efforts to enter upon studies for which he was not fitted.

As to insanity among the Indians of the present day, there seems to be some diversity of opinion. Dr. Felix M. Adams, superintendent of the East Oklahoma Hospital for the Insane, Vinita, Okla., states that "from what investigation I have made I find that insanity is not very prevalent among the full-blooded Indians."

[1] See "The Care of the Insane in Washington" in a subsequent volume, case of "Archibald Petton."

Dr. D. W. Griffin, superintendent of the Oklahoma Hospital for the Insane at Norman, Okla., writes under date of April 8, 1914, as follows:

"Since my connection with the insane of this state (Oklahoma) I have come to the belief that the Indians are as subject to insanity if not more so than the white citizen.

"We find now that as the country is being taken up by the white man and the Indian becoming more enlightened and accustomed to the white race, educationally and otherwise, he is more ready to submit a case of insanity for consideration of the courts. And we find therefore that the percentage of insanity among the Indians is certainly equal to that of the white man.[1]

"If it were possible to take into account feeble-mindedness and epilepsy among the Indians, the percentage would be considerably greater."

In 1898-1899 the United States Government established at Canton, S. Dak., an asylum intended for the treatment of insane Indians exclusively, especially those Indians who retain a tribal relation and for whom, as they are considered wards of the government pure and simple, the government under treaty regulations is considered to be responsible.

There had been more or less insanity among the Indians on the different reservations for many years, and the relatives and friends who, among civilized communities, are held responsible for these unfortunates, were absolutely unfit for such responsibility, because, in addition to lack of experience, of proper accommodations and of food, all Indians have a superstitious horror of persons showing any peculiarity of manner or conduct. As previously stated, they believed that such persons were possessed of a devil and should be put out of existence or left entirely alone.

No Indian agency of the government was prepared to assume the care of insane people. It was already obvious that among full-blooded Indians there were types of insanity corresponding identically with types of mental and nervous trouble among white people,

[1] According to the census of 1904, there were in hospitals for the insane on December 31, 1903, 58 Indians; while in 1904 there were admitted to hospitals 27 Indians. The census for 1910 shows that out of a total population of 265,683, there were in hospitals for the insane 166 Indians; a ratio of 62.5 per 100,000 of population.

even the most civilized. The former superintendent of the asylum at Canton, S. Dak., investigated three cases of insanity reported to him which were caused by financial anxiety, pure and simple, brought on by the prospective loss of property as definitely as any observed upon the Stock Exchange or Board of Trade in New York or Chicago. Cases of insanity among Indians from financial embarrassment are doubtless rare. There are, however, cases of insanity among full-blooded Indians due to domestic infelicity, to loss of children and other relatives, and to religious mania, as well as other types as clear and distinct as they are among white men. There are also cases of alcoholic mania as well as of homicidal and other criminal manias. Mental and nervous disorders, including epilepsy, are prevalent. These statements refer only to full-blooded Indians. Among those of mixed blood all types of insanity are present.

The establishment of the asylum at Canton was a most beneficent and humane expenditure on the part of the government for the protection and care of an absolutely helpless and dependent people.

In all of the 120 years of the active and settled policy of the government in its business relations with the American Indian, no steps had been taken by the government for the protection and care of this most unfortunate and helpless class among the American Indians, until the establishment of the Asylum for the Insane Indians at Canton, S. Dak.

We have appended herewith as a separate chapter liberal extracts from a paper entitled "Insanity Among the Indians at the Asylum for Insane Indians, Canton, S. Dak.," by H. R. Hummer, M. D., superintendent.

III.

INSANITY AMONG THE INDIANS AT THE ASYLUM FOR INSANE INDIANS, CANTON, S. DAK.[1]

In an Indian population of more than 300,000 in the United States there were June 30, 1911, 58 insane Indians in the asylum at Canton, S. Dak.; 52 applications on file, necessarily deferred because of limited accommodation; 20 or more cases in various state institutions and upwards of 20 others cared for by relatives or friends of the more civilized class. This gives a total of upwards of 150 known cases of insanity, a ratio of 1 to 2000. As a matter of fact, judging from the reports of employees and sane Indians of several of the 140 schools and reservations throughout the United States, there must be at least double this number, or a ratio of 1 to 1000 of the population. For instance, there are from 15 to 20 epileptics on the Flathead Reservation in Montana, the majority of whom present symptoms of mental alienation. Possibly this may be accounted for by the fact that this tribe binds the heads of the infants to make them flat, from which custom they received their name. Scarcely an employee or an enlightened Indian from any of the reservations visits this asylum who does not affirm that he knows of from one to five cases on that reservation who should properly be in the asylum. It must be remembered that this is the judgment of laymen, but there must be a foundation of fact behind this judgment. These cases are not brought to the attention of the various superintendents or physicians, owing to the reticence and superstitions of the Indians. It is not surprising that superintendents and physicians do not find them when one considers the enormous territory under their jurisdiction.

Another factor of importance is the faith of the older full-bloods in their own medicine men, who treat insane cases by incantations, herbs and other means. Recently, commissions have been appointed by the Indian Office, to visit the various schools and reservations to determine from an examination what Indians are competent to receive lands and to become self-supporting citi-

[1] By H. R. Hummer, M. D., superintendent.

zens. In the findings of one commission, out of 700 Indians on a single reservation 350 were found to be competent; 250 incompetent; and the status of 100 was undecided at the time of the report. These 250 incompetents were probably not so designated because of ignorance or lack of education alone, but many were undoubtedly incompetent from idiocy, imbecility, constitutional inferiority, epileptic psychosis, organic brain disease, senile dementia and other forms of mental disease, unrecognized by a commission composed of laymen. It is impossible to foretell the results of similar commissions at other schools and agencies, but it is fair to assume that additional cases will be found at each. If this be true the estimate of 1 insane person in 1000 may prove far too low.

In the 126 cases admitted from the opening of the asylum at Canton, S. Dak., to June 30, 1911, the diagnoses in the records show the following types: melancholia, circular insanity, climacteric insanity, manic-depressive insanity, epileptic idiocy, epileptic dementia, epileptic imbecility, epileptic psychoses, amentia, imbecility, high grade congenital imbecility, alcoholic dementia, dipsomania, toxic insanity, alcoholic insanity, intoxication psychoses, dementia, epilepsy, syphilitic epilepsy, epilepsy with hemiplegia, cortical epilepsy, traumatic epileptic dementia, dementia præcox, infantile spastic diplegia, spastic spinal paralysis, kleptomania, nymphomania, mutism, sexual neurasthenia, paresis, galloping paresis, syphilitic dementia. This classification (?) has been revised as accurately as the lack of records permits and at the end of the last fiscal year the records carried nine types, viz., dementia præcox, 15; the epilepsies, 14; congenital imbecility, 8; intoxication psychoses, 6; manic-depressive insanity, 5; senile psychoses, 6; arterio-sclerotic dementia, 2; hysteria, 1; paranoia, 1. The records are far from complete or satisfactory.

The 126 admissions were: from Arizona, 12; California, 1; North Dakota, 7; South Dakota, 22; District of Columbia, 1; Idaho, 3; Kansas, 3; Minnesota, 16; Montana, 7; Nebraska, 3; Nevada, 2; New Mexico, 8; Oklahoma, 27; Oregon, 3; Washington, 1; Wisconsin, 8; Wyoming, 2.

Of the tribes represented, the Sioux have contributed the largest number, 25, followed closely by the Chippewa with 19. Then in order we have the Navajo, 8; Apache and Cherokee, 5 each;

Menominee, Osage Piute, 4 each; Bannock, Blackfeet, Choctaw, Creek and Winnebago, 3 each; Arickaree, Caddo, Chickasaw, Flathead, Pima, Pueblo and Seminole, 2 each; and 1 each of the following: Arapaho, Cheyenne, Cree, Crow, Gros Ventres, Hopi, Kickapoo, Klamath, Mesa Grande, Modoc, Moqui, Papago, Pawnee, Piegan, Potawatomi, Puyallup, Quapaw, Sac and Fox, Shawnee, Shoshone, Umatilla, Wyandotte and unknown. It should be remembered that the Sioux and Chippewa are large tribes in the immediate vicinity of the asylum.

The records show 13 cases due to congenital defect, 8 male and 5 female, four of these having epilepsy as a leading causative factor, followed closely by epilepsy with 11 cases, 6 females and 5 males; third in order appears alcohol, which is charged with producing insanity in six cases, 4 men and two women; senility ranks fourth with 5 cases, 3 females and 2 males; arterio-sclerosis in 2 cases, 1 male and 1 female; the puerperium in one and domestic difficulties in another. This leaves 16 cases with an unknown etiological factor. In these cases we find heredity, head-injury, constitutional inferiority, prison-life, domestic troubles, menstrual disorders, the climacterium, worry, grief, over-eating, over-medication, fright, exposure, frequent pregnancies, and consanguinity in the parents, given as possible contributing factors, but in none is the history sufficiently clear to warrant removing them from the class of unknown etiology. As to heredity, one patient, classed as a congenital imbecile, was the offspring of parents who were brother and sister; a case of manic-depressive insanity, covering a period of 45 years, showing "insanity in the father's family" and "peculiarities, intemperance and melancholy in the mother's family"; one case of dementia præcox shows a maternal cousin epileptic; a congenital imbecile has a history of a "foolish father"; another is the offspring of a consumptive mother; an epileptic imbecile springs from a syphilitic mother; a case of dementia præcox had "a brother, aunt and uncle mentally unbalanced"; and a manic-depressive case shows an "eccentric father and an insane grandfather," whether maternal or paternal is unknown. The histories are fragmentary, in many instances totally lacking, and in others unreliable. This may be explained by the fact that the Red Man is extremely reticent concerning insanity among his ancestors and relatives because of his superstitions as to witchcraft.

A case of arterio-sclerotic dementia now under treatment was absolutely neglected by her relatives following an apoplectic stroke, because another relative, dying of tuberculosis, claimed to have a vision of this woman, just before her death. According to the Indian conception, this vision proved conclusively that the patient was possessed of devils and had poisoned the relative. She would have died from neglect and exposure had it not been for the kindness of a more enlightened neighbor, when her relatives refused to go near her. Mr. Gifford, a former superintendent of the asylum at Canton, in the annual report for 1902 states that "the condition of the larger number of these patients, mentally and physically, when received into the asylum, indicates extreme neglect in their former care and treatment. Some of these unfortunate people have no relatives or friends who are responsible, either legally or morally, for their care and support and some Indians are quite superstitious regarding insanity and will have nothing to do with an insane relative or friend, except to get rid of him in the quickest and easiest manner possible." This statement is not at all exaggerated, except in a few cases, whose relatives have attended the Indian schools sufficiently long to overcome such superstitions. In these cases there is practically no difference between the care given the afflicted Indian and that given his white brethren. It would appear that domestic difficulty is an especially prominent factor in the causation of mental disease in the Indian race. The marriage vows, generally speaking, are not held inviolable, with the result that it is not unusual to hear of children the offspring of father and daughter, brother and sister, and of equally close relations. This may be partially explained by their mode of living, in many instances all the members of the family living in one tepee, hogan or room, which, when taken with the voracious appetites and indolence of the males, causes the sexual function, rather than muscular action, to become a safety valve for the system. The amount of restraint placed upon the sexual desire is much less than in the white race.

So far as sex is concerned, out of 126 cases admitted, 72 were males, a percentage of 57 plus, and 54 females, a percentage of 42 plus.

The degree of Indian blood as a causative factor may be shown by the fact that out of 126 admissions, 84 were full-bloods, 38 half-

bloods, three less than half and one unknown, giving a percentage of 66 2-3 for the full bloods.

Age as a causative factor is shown by the following table based on 126 admissions: Two in the first decade; 18 in the second; 28 in the third; 36 in the fourth; 15 in the fifth; 10 in the sixth; 7 in the seventh; 7 in the eighth; and 3 beyond the eighth decade. An old lady is 102 years old.

Marital conditions of the 58 in the asylum June 30, 1911: 24 were single, 19 married, 11 widowed, 1 divorced and 3 unknown. The lack of records makes it impossible to give these data for all admissions.

Symptomatology.—Indian manic-depressives present nothing materially different from whites afflicted with the same disease.

I have observed no instances of imperative conceptions and the physical symptoms were inconsequential.

The epileptics here differ in no manner from the white epileptics I have seen, except that five out of the 14 have a condition of hemiplegia, three of the left side and two of the right, the exact relation of the epilepsy and hemiplegia being unknown at this time. One case of epilepsy is purely nocturnal and several others practically nocturnal, though they occasionally suffer a convulsion during the day. One epileptic has his convulsions serially, averaging 18 to 20 every third week, and another averages 40 to 50 convulsions monthly in spite of fairly large doses of triple bromides.

Congenital imbeciles present nothing startling, except that all are of very low intelligence.

The only striking symptom among alcoholic cases seems to be active homicidal impulses which were present in each of the six cases, one man having actually killed several persons, another shooting at some strangers passing his farm, another attempting an assault with an ax, a female threatening to kill her family by "chopping off their heads," another by assaulting those around with whatever she could lay her hands on, and the sixth by vicious assaults without warning at every opportunity. Otherwise their symptoms did not differ materially from those occurring in the white alcoholics. Five or six are dementing types and the sixth is a case of chronic alcoholic hallucinosis.

Senile psychoses present no differences from corresponding psychoses in the white race.

Hebephrenics have the same eccentricities, vague, suspicious self-centering, distrustfulness, emotional outbursts of superficial character, occasional self-complacency, lack of initiative, somato-psychic delusions, hallucinations, mostly of an elementary character, apathy, silly smiles, impulsivity, irrelevant replies, negativism, stereotypies of speech and attitude, "word salad" and automatism.

Catatonic cases show alternating periods of depression and excitement, stupor, motor disturbances, mutism, negativism, stereotypies of speech and action, cerea flexibilitas, psycho-motor retardation, apathy, lack of interest, embarrassment, impulsivity, destructiveness, hallucinations, delusions and aggressiveness. Our dementia præcox (paranoid form) present dementia, fixed systemized delusions of a bizarre nature, fantastic hallucinations, controlling the actions of the patients, defective memory, hypochondriacal ideas, occasional impulsive acts or mannerisms, verbigeration, and automatism.

A true paranoiac is extremely interesting, having been abroad and demanded that the throne of Denmark be vacated in her favor.

In general, then, Indians present practically the same mental symptoms as corresponding forms of mental disease among the whites. They are more suspicious, at least until their confidence is gained, much more reticent and their superstitions are fully as prominent as those of the plantation negro. They are probably more destructive and decidedly filthier than the white insane. They give little trouble by their attempts to escape, there having been no escape from this institution in two and a half years. There seems little danger of suicide, though one case has made repeated abortive attempts at self-destruction, always by hanging.

Diagnosis.—It is harder to diagnose the mental condition of the insane Indian because of his reticence, suspiciousness, superstitions, etc., and from the fact that oftentimes the only medium of conversation is the sign language, which is very crude.

Prognosis.—Out of 126 admissions there have been 41 deaths, 16 recoveries, 9 improvements or unimprovements, 2 escapes and 58 remain, all of whom are chronically insane.

Treatment.—Custodial care and attention, together with encouragement and suggestion, regulation of hours for rest, eating,

exercise and recreation, careful attention to diet and strict enforcement of the laws of health and sanitation, constitute the routine measures. Epileptics are given a routine treatment of the triple bromides and such other sedatives as are required. Seldom is it necessary to resort to hypnotics, although an occasional hot bath is found to be beneficial. Games of all sorts are encouraged, such as baseball, horseshoes, fishing, trapping, croquet and athletics of all sorts; also such indoor recreation as checkers, cards, dominoes, basket-work, raffia-work, bead-work and fancy sewing. Physical labor for those capable of performing it is aided and abetted to the fullest extent. Trips to town and the near-by river assist in breaking the monotony. Weekly congregations for the singing of sacred music are beneficial.

IV.

THE CHINESE AND JAPANESE INSANE IN THE UNITED STATES.

In the 11th census of the United States, as of the year 1890, the total number of Chinese insane reported was 196. This was a ratio of 182 per 100,000 of the Chinese population living in the United States on June 1, 1890. Of the 196 Chinese insane, 188 were males and 8 were females. The proportion of insane among the Chinese is small, when it is taken into consideration that the Chinese population consists mainly of adults.

The total number of Japanese insane reported in 1890 was 3, all males.

The census report for 1910 does not give the Chinese and Japanese separate enumeration, but reports, out of a total of 187,791 insane enumerated of "other colored" races, 491 persons, "mostly, if not entirely, Chinese and Japanese."[1]

APPENDIX.

From a "Narrative of the Adventures and Sufferings of John R. Jewitt, Only Survivor of the Crew of the Ship Boston, During a Captivity of Nearly Three Years Among the Savages of Nootka Sound."

Tootoosch, his father, was esteemed the first warrior of the tribe, and was one who had been particularly active in the destruction of our ship, having killed two of our poor comrades, who were ashore, whose names were Hall and Wood. About the time of our removal to Tashees, while in the enjoyment of the highest health, he was suddenly seized with a fit of delirium, in which he fancied that he saw the ghosts of those two men constantly standing by him, and threatening him, so that he would take no food, except what was forced into his mouth. A short time before this he had lost a daughter of about fifteen years of age, which afflicted him greatly, and whether his insanity, a disorder very uncommon among these savages, no instance of the kind having occurred within the memory of the oldest man amongst them, proceeded from this cause, or that it was

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[1] "Insane in Hospitals, etc." Bureau of the Census, Washington, D. C., 1914, page 25.

the special interposition of an all-merciful God in our favor, who, by this means, thought proper to induce these barbarians still further to respect our lives, or that, for hidden purposes, the Supreme Disposer of Events sometimes permits the spirits of the dead to revisit the world and haunt the murderer, I know not, but his mind from this period until his death, which took place but a few weeks after that of his son, was incessantly occupied with the images of the men whom he had killed.

This circumstance made much impression upon the tribe, particularly the chiefs, whose uniform opposition to putting us to death, at the various councils that were held on our account, I could not but in part attribute to this cause, and Maquina used frequently, in speaking of Tootoosch's sickness, to express much satisfaction that his hands had not been stained with the blood of any of our men.

When Maquina was first informed by his sister of the strange conduct of her husband, he immediately went to his house, taking us with him, suspecting that his disease had been caused by us, and that the ghosts of our countrymen had been called thither by us to torment him. We found him raving about Hall and Wood, saying that they were "peshak," that is, bad. Maquina then placed some provision before him, to see if he would eat. On perceiving it, he put forth his hand to take some, but instantly withdrew it with signs of horror, saying that Hall and Wood were there, and would not let him eat. Maquina then pointing to us, asked if it was not John and Thompson that troubled him. "Wik," he replied, that is, no. John "klushish"—Thompson "klushish"—John and Thompson are both good; then turning to me, and patting me on the shoulder, he made signs for me to eat. I tried to persuade him that Hall and Wood were not there, and that none were near him but ourselves; he said, "I know very well that you do not see them, but I do."

At first, Maquina endeavored to convince him that he saw nothing, and to laugh him out of his belief; but finding that all was of no purpose, he at length became serious, and asked me if I had ever seen anyone affected in this manner, and what was the matter with him. I gave him to understand, pointing to his head, that his brain was injured, and that he did not see things as formerly.

Being convinced by Tootoosch's conduct that we had no agency in his indisposition, on our return home Maquina asked me what was done in our country in similar cases. I told him that such persons were closely confined, and *sometimes tied up and whipped, in order to make them better.* After pondering for some time, he said that he should be glad to do anything to relieve him, and that he should be whipped, and immediately gave orders to some of his men to go to Tootoosch's house, bind him and bring him to his, in order to undergo the operation. Thompson was the person selected to administer this remedy, which he undertook very readily; and for that purpose provided himself with a goodly number of spruce branches, with which he whipped him most severely, laying it on with the best will imaginable, while Tootoosch displayed the greatest rage, kicking, spitting, and attempting to bite all who came near him.

This was too much for Maquina, who, at length, unable to endure it longer, ordered Thompson to desist, and Tootoosch to be carried back, saying that, if there was no other way of curing him but by whipping, he must remain mad.

The application of the whip produced no beneficial effect on Tootoosch, for he afterwards became still more deranged; in his fits of fury sometimes seizing a club, and beating his slave in a most dreadful manner, and striking and spitting at all who came near him, till, at length, his wife, no longer daring to remain in the house with him, came with her son to Maquina's.

CHAPTER XII

INSTITUTIONAL POPULATION OF THE INSANE AND FEEBLE-MINDED

CENSUS OF THE INSANE

I.

INSTITUTIONAL POPULATION.

The number of patients cared for in the earlier established hospitals for the insane was strictly limited. This was in a great measure due to the fact that the hospitals were designed for a class of patients "furiously mad" or "dangerous to be at large," and that the idea of insanity as a disease, capable of cure, was unthought of. The measure of care meted out to these unfortunates was of a custodial character only, and such "maniacs" as were admitted were only too likely to end their days in the asylum. Thus we find that the number of patients admitted at Williamsburg, the Pennsylvania Hospital and Bloomingdale Asylum in the earlier days of their existence manifestly constituted but a small proportion of the insane then existing in the localities ministered to by those hospitals. The fact that the care of insane dependents was a local matter, and the reluctance of county boards and township organizations to assume the financial burden which placing the indigent insane in hospitals would entail, alone were sufficient to limit strictly the number sent to the early hospitals.

In this respect the figures upon page 400, showing the admissions to the Hartford Retreat, which, although an asylum of a semi-private class, had an arrangement with the towns of Connecticut, and received patients at a rate of payment less than the actual cost of treatment, are of interest.

The figures given are for the period 1824-1856, since which date, owing to the establishment of other institutions, the number of admissions has increased but slowly.

At the New York Hospital, now the Bloomingdale Hospital, the total number of insane received previously to December 31, 1803, was only 215.

At the time of the opening of the new Bloomingdale Asylum in 1821 there were but four other public institutions exclusively devoted to the insane in the United States. By 1844 16 new asylums were in operation, making the total number in the country 21. In 1849 the total number of insane patients cared for in institutions, both public and private, in New York State was less than 1200.

OPERATIONS OF THE RETREAT FROM THE BEGINNING OF EACH YEAR.

Year.	Admitted.			Discharged.												Daily average number.
				Recovered.			Improved.			Stationary.			Died.			
	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Total.
1824–5	...	...	44	...	...	10	...	...	...	...	...	...	...	...	1	...
1825–6	...	...	33	...	...	16	...	...	...	...	...	...	...	...	1	...
1826–7	...	...	37	...	...	24	...	...	...	...	...	...	...	...	0	...
1827–8	...	...	40	...	...	27	...	...	...	...	...	...	...	...	4	...
1828–9	...	...	42	...	...	26	...	...	...	...	...	...	...	...	2	...
1829–30	...	...	51	...	...	28	...	...	...	...	...	...	...	...	0	...
1830–1	...	...	53	...	...	32	...	...	...	...	...	...	...	...	1	...
1831–2	...	...	80	...	...	46	...	...	...	...	...	...	...	...	6	...
1832–3	...	...	68	...	...	37	...	...	...	...	...	...	...	...	4	...
1833–4	...	...	72	...	...	43	...	...	...	...	...	...	...	...	3	...
1834–5	...	...	72	...	...	36	...	...	...	...	...	...	...	...	6	...
1835–6	...	...	73	...	...	42	...	...	...	...	...	...	...	...	6	...
1836–7	...	...	91	...	...	55	...	...	...	...	...	...	...	...	6	...
1837–8	...	...	67	...	...	42	...	...	...	...	...	...	...	...	10	...
1838–9	...	...	94	...	...	49	...	...	...	...	...	...	...	...	8	...
1839–40	...	...	84	...	...	50	...	...	...	...	...	...	...	...	2	...
1840–1	...	...	67	...	...	38	...	...	...	...	...	...	...	...	9	...
1841–2	45	51	96	27	29	56	6	10	16	6	3	9	6	2	8	...
1842–3	50	33	83	26	19	45	11	13	24	...	...	...	4	3	7	...
1843–4	51	29	80	26	18	44	26	17	43	...	...	...	5	4	9	84
1844–5	56	49	105	23	22	45	13	7	20	7	2	9	7	4	11	97
1845–6	56	72	128	24	36	60	17	15	32	9	3	12	5	11	16	121
1846–7	50	61	111	16	40	56	22	13	35	1	6	7	8	3	11	127
1847–8	39	54	93	12	28	40	13	11	24	7	6	13	4	8	12	127
1848–9	49	84	133	20	50	70	8	15	23	12	5	17	7	5	12	141
1849–50	60	75	135	17	47	64	11	13	24	3	4	7	17	13	30	143
1850–1	56	72	128	25	34	59	15	11	26	8	6	14	9	6	15	151
1851–2	68	90	158	26	42	68	10	12	22	7	15	22	9	13	22	168
1852–3	66	74	140	32	32	64	18	22	40	13	13	26	10	11	21	179
1853–4	74	103	177	22	42	64	16	26	42	14	19	33	13	9	22	180
1854–5	69	100	169	26	47	73	20	18	38	18	16	34	9	8	17	185
1855–6	70	87	157	18	41	59	17	28	45	10	13	23	12	14	26	187

Two years later the Association of Medical Superintendents of American Institutions for the Insane, at their sixth annual meeting, held in Philadelphia, May 19, 1851, adopted a series of "Propositions"[1] which were formulated for the construction of hos-

[1] See "The Propositions," page 217.

pitals for the insane. One section provided that not more than 250, and preferably 200, patients should be placed in one building. This limitation of capacity of proposed hospitals was extended to a permissible accommodation of 600 in 1866. This limitation was speedily passed, however, the need of care for insane patients in rapidly growing states becoming so great that before many years had passed many institutions were already caring for from 1000 to 1200 patients. The first notable departure from the "Propositions" was at Willard, N. Y., where provision was made for accommodations for 2000 patients of the chronic class. They were housed in a series of block buildings with a central or administration building. This method of construction was followed by the adoption of the "cottage plan," the first example of which was established at Kankakee, Ill., in 1877. The result of this method of construction has been practically to remove all restrictions as to the number of insane patients to be cared for in any one hospital, and we now have hospitals with populations of patients and employees of 3000, 4000 and even larger.

The following table showing the population in the various public and private hospitals within the United States as of January 1, 1910, has been compiled from the Insane and Feeble-minded in Institutions, 1910, Bureau of the Census.[1]

These are the latest available figures showing the number of insane in the hospitals within the United States at any one date. Since the date of this enumeration the population of many of the hospitals as given has increased largely. There have been also many additional hospitals established. The names of the various hospitals are given as of January 1, 1910, although since that date many of the states have changed the titles of their institutions.

ALABAMA.

Public:	
The Bryce Hospital	1,429
The Mount Vernon Hospital	610
Total	2,039

ARIZONA.

Public:	
Territorial Asylum for the Insane	337

[1] Washington, Government Printing Office, 1914.

ARKANSAS.

Public:

State Hospital for Nervous Diseases	1,092

CALIFORNIA.

Public:

Agnew State Hospital	698
Mendocino State Hospital	856
Napa State Hospital	1,841
Southern California State Hospital	1,270
Stockton State Hospital	1,895
Private	92
Total	6,652

COLORADO.

Public:

Colorado State Insane Asylum	882
Denver City and County Hospital	128
Private	189
Total	1,199

CONNECTICUT.

Public:

Connecticut Hospital for the Insane	2,436
Norwich Hospital for the Insane	623
Private:	
Hartford Retreat	156
Other institutions	364
Total	3.579

DELAWARE.

Public:

Delaware State Hospital	441

DISTRICT OF COLUMBIA.

Public:

Government Hospital for the Insane	2,890

FLORIDA.

Public:

Florida Hospital for the Insane	849

GEORGIA.

Public:

Georgia State Sanitarium	3,082
Private:	
Allen's Invalid Home	50
Total	3,132

IDAHO.

Public:	
The Idaho Insane Asylum	259
The Northern Idaho Insane Asylum	129
Total	388

ILLINOIS.

Public:	
Anna State Hospital	1,478
Chester State Hospital	215
Elgin State Hospital	1,384
Jacksonville State Hospital	1,440
Kankakee State Hospital	2,549
Peoria State Hospital	2,107
Watertown State Hospital	1,412
Cook County Hospital for Insane	2,174
Madison County Poor Farm	4
Private	76
Total	12,839

INDIANA.

Public:	
Central Indiana Hospital for Insane	1,815
Eastern Indiana Hospital for Insane	795
Northern Hospital for Insane	978
Southern Indiana Hospital for Insane	724
Marion County Asylum for Insane	189
Private	26
Total	4,527

IOWA.

Public:	
Cherokee State Hospital	887
Clarinda State Hospital	1,054
Independence State Hospital	1,161
Mount Pleasant State Hospital	1,020
County asylums	642
Private:	
Mercy Hospital, Davenport	156
St. Bernard's Hospital, Council Bluffs	209
St. Joseph's Sanitarium, Dubuque	230
The Retreat, Des Moines	18
Total	5,377

KANSAS.

Public:	
Hospital for Epileptics	303
Osawatomie State Hospital	1,294
Topeka State Hospital	1,215
Private	100
Total	2,912

KENTUCKY.

Public:	
Central Kentucky Asylum for the Insane	1,352
Eastern Kentucky Asylum for the Insane	1,063
Western Kentucky Asylum for the Insane	1,072
Private	51
Total	3,538

LOUISIANA.

Public:	
East Louisiana Hospital for the Insane	1,362
Louisiana Hospital for Insane	553
Private:	
Louisiana Retreat, New Orleans	243
Total	2,158

MAINE.

Public:	
Eastern Maine Insane Hospital	347
Maine Insane Hospital	911
Total	1,258

MARYLAND.

Public:	
Maryland Hospital for the Insane	586
Springfield State Hospital	946
Bay View Hospital	438
County asylums	354
Private:	
Mount Hope Retreat	623
The Sheppard and Enoch Pratt Hospital	102
Other institutions	171
Total	3,220

MASSACHUSETTS.

Public:	
Boston State Hospital	777
Bridgewater State Hospital	657
Danvers State Hospital	1,391
Medfield Insane Asylum	1,604
Monson State Hospital	333
Northampton State Hospital	839
State Colony for the Insane, Gardner	586
State Infirmary, Tewksbury	711
Taunton State Hospital	970
Westborough Insane Hospital	978
Worcester State Asylum	1,148
Worcester State Hospital	1,316
Private:	
McLean Hospital	224
Other institutions	67
Total	11,601

MICHIGAN.

Public:	
Eastern Michigan Asylum	1,343
Michigan Asylum for the Insane	1,900
Northern Michigan Asylum	1,396
State Asylum, Ionia	408
State Psychopathic Hospital	41
Upper Peninsula Hospital for the Insane	758
Wayne County Asylum	535
Private:	
St. Joseph's Retreat, Dearborn	259
Other institutions	59
Total	6,699

MINNESOTA.

Public:	
Anoka State Asylum	479
Fergus Falls State Hospital	1,574
Hastings State Asylum	478
Rochester State Hospital	1,201
St. Peter State Hospital	1,005
Private	7
Total	4,744

MISSISSIPPI.

Public:

East Mississippi Insane Hospital	536
State Insane Hospital	1,442
Total	1,978

MISSOURI.

Public:

State Hospital No. 1	1,104
State Hospital No. 2	1,341
State Hospital No. 3	1,191
State Hospital No. 4	586
St. Louis City Insane Asylum	693
St. Louis Poorhouse	737
County asylums	30
Private:	
St. Vincent's Institution, St. Louis	301
Other institutions	185
Total	6,168

MONTANA.

Public:

Montana State Hospital for the Insane	697

NEBRASKA.

Private:

Nebraska Hospital for the Insane	569
Nebraska State Hospital	1,146
Norfolk State Hospital	275
Total	1,990

NEVADA.

Public:

Nevada Hospital for Mental Diseases	230

NEW HAMPSHIRE.

Public:

New Hampshire State Hospital	876
Rockingham County Farm	28
Private	5
Total	909

NEW JERSEY.

Public:	
New Jersey State Hospital, Morris Plains	2,056
New Jersey State Hospital, Trenton	1,342
Essex County Hospital for the Insane	1,277
Hudson County Hospital for the Insane	668
Other county hospitals	686
Private	13
Total	6,042

NEW MEXICO.

Public:	
New Mexico Insane Asylum	219

NEW YORK.

Public:	
Binghamton State Hospital	2,282
Buffalo State Hospital	1,912
Central Islip State Hospital	3,994
Dannemora State Hospital	369
Gowanda State Homeopathic Hospital	995
Hudson River State Hospital	2,937
Kings Park State Hospital	3,117
Long Island State Hospital	764
Manhattan State Hospital	4,400
Matteawan State Hospital	763
Middletown State Homeopathic Hospital	1,764
Rochester State Hospital	1,320
St. Lawrence State Hospital	1,844
Utica State Hospital	1,369
Willard State Hospital	2,321
Private:	
Bloomingdale Hospital for Insane	337
Other institutions	792
Total	31,280

NORTH CAROLINA.

Public:	
State Hospital, Goldsboro	668
State Hospital, Morganton	1,193
State Hospital, Dix Hill	578
State Hospital for Dangerous Insane	50
Private	33
Total	2,522

NORTH DAKOTA.

Public:

State Hospital for Insane	628

OHIO.

Public:

Athens State Hospital	1,336
Cleveland State Hospital	1,447
Columbus State Hospital	1,743
Dayton State Hospital	1,195
Longview Hospital	1,284
Massillon State Hospital	1,571
Toledo State Hospital	1,796
Private:	
Cincinnati Sanitarium	82
Other institutions	140
Total	10,594

OKLAHOMA.

Public:

Oklahoma Hospital for the Insane, Supply	471
Private:	
The Duke Sanitarium	11
Oklahoma Hospital for the Insane, Norman	628
Total	1,110

OREGON.

Public:

Oregon State Insane Asylum, Salem	1,565

PENNSYLVANIA.

Public:

The Dixmont Hospital	975
Pennsylvania State Lunatic Hospital	1,169
State Asylum for Chronic Insane	851
State Hospital for Insane, Danville	1,486
State Hospital for Insane (men), Norristown	1,305
State Hospital for Insane (women), Norristown	1,441
State Hospital for the Insane, Warren	1,329
Allegheny County Hospital for the Insane	652
Blair County Hospital for the Insane	207
Chester County Hospital for Insane	266
Cumberland County Hospital for Insane	87
Hillside Home	441
Lancaster County Hospital	259
Luzerne County Hospital for Insane	589

Potter County Home and Asylum	36
Somerset County Home and Hospital	100
Schuylkill County Almshouse	111
Philadelphia Hospital for Insane	2,174
Pittsburgh City Home and Hospital	597
Pittsburgh North Side City Home	212
Private:	
Friends Asylum	171
Pennsylvania Hospital for the Insane	434
Other institutions	166
Total	15,058

RHODE ISLAND.

Public:	
State Hospital for the Insane	1,101
Private:	
Butler Hospital	142
Total	1,243

SOUTH CAROLINA.

Public:	
State Hospital for the Insane	1,541

SOUTH DAKOTA.

Public:	
Asylum for Insane Indians	60
South Dakota State Hospital	804
Total	864

TENNESSEE.

Public:	
Central Hospital for Insane	642
Eastern Hospital for Insane	515
Western Hospital for Insane	679
County asylums	368
Total	2,195

TEXAS.

Public:	
North Texas Hospital for Insane	1,851
Southwestern Insane Asylum	757
State Lunatic Asylum	1,377
Private	68
Total	4,053

UTAH.

Public:

State Mental Hospital	342

VERMONT.

Public:

Vermont State Hospital for the Insane	572
Private:	
Brattleboro Retreat	402
Lakeview Sanitarium, Burlington	16
Total	990

VIRGINIA.

Public:

Central State Hospital	1,340
Eastern State Hospital	674
Southwestern State Hospital	580
Western State Hospital	1,041
Total	3,635

WASHINGTON.

Public:

Eastern Washington Hospital for Insane	696
Western Washington Hospital for Insane	1,291
Total	1,987

WEST VIRGINIA.

Public:

Second Hospital for Insane	505
West Virginia Asylum	235
West Virginia Hospital for Insane	982
Total	1,722

WISCONSIN.

Public:

Northern Hospital for the Insane	635
The State Hospital for the Insane	621
County asylums	5,180
Private	151
Total	6,587

WYOMING.

Public:

Wyoming State Hospital for the Insane	162

II.

CENSUS OF THE INSANE.

Prior to the United States census of 1840 no enumeration was attempted by the federal government of the insane residing in the different states. The census for that year, however, has a distinct enumeration, under the heading, "Insane and Idiots," and further divided into "white" and "colored and slaves."

In the sixth report of the Prison Discipline Society of Massachusetts, page 64, it is stated that:

"By a late report to the Legislature it appears that there were in 1825, in the State of New York, 819 lunatics; 1421 idiots; total 2240; or one to every 721 souls. Of the lunatics only 263 were able to pay for their support; the other 556 lunatics were insane paupers, either confined in private families, poorhouses or jails, or roaming at large."

In the eighth report of the Prison Discipline Society for 1833, page 24, it is stated:

"We estimate the number of lunatics as 1 to 1000 of the whole population, or the whole number of lunatics in the United States at 12,000. We estimate the proportion of this class of persons in prisons, houses of correction and almshouses at one-fifth part of the whole number, or 2400."

In the ninth report of the Prison Discipline Society, 1833, page 85, referring to an investigation that had been made the previous year as to the number of insane then residing in the State of New Hampshire, the following statement is made:

"When the examination was made, one year after, and from the official returns, the committee were prepared to submit their report. They made the following statement:

"The number of insane, as returned to the Governor, is 201, more than half of whom are supported as paupers. From many towns no returns have been received; from others, the accounts are erroneous, there being cases known to the committee which escaped the notice of the selectmen. The actual number of insane, therefore, is much larger than appears by the documents submitted by the committee."

The report further states that the above statement is sufficient foundation for the estimate that the lunatics in the United States are nearly as 1 to 1000 of the population; or as follows:

Maine	399	South Carolina	516
New Hampshire	269	Kentucky	687
Vermont	280	Tennessee	681
Massachusetts	610	Ohio	935
Rhode Island	97	Louisiana	215
Connecticut	297	Indiana	139
New York	1,918	Illinois	157
New Jersey	320	Alabama	309
Pennsylvania	1,348	Missouri	140
Delaware	76	Michigan	31
Maryland	447	Arkansas	30
Virginia	1,211	Florida	35
North Carolina	737	District of Columbia	39
			11,923

This list contains no return from Georgia, the population of which was, in 1832, 516,832; nor Mississippi with 136,621.

The population of the United States, as appears from a letter of the Secretary of State to the Speaker of the House of Representatives, dated January 4, 1832, was not exactly ascertained at the fifth census. The returns for the territories of Florida, Arkansas and Michigan and the District of Columbia were wanting. Mr. W. Gore Ousely, in his "Remarks on the Statistics and Political Institutions of the United States," says (p. 197) that "the whole population of the United States probably amounts at present (1832) to as nearly as possible 13,000,000."

In the 16th report of the Prison Discipline Society, 1841, page 12, occurs the following:

"Dr. Brigham says, 'In the year 1835 there were received in three of the institutions in Massachusetts, from that state alone, 124 patients, who became crazy that year.' This number is estimated by the same author to be probably not more than half who became insane in the same state, during the same period. If this statement and opinion be made the basis of an estimate, it will give as the number who become insane annually in the United States 5719."

According to the United States census of 1840 the number of insane and idiots was 1 to 990 of population. The following table shows the figures by states:

INSANE AND IDIOTS.

Total Population.		White		Colored and Slaves	
		Public Charge.	Private Charge.	Public Charge.	Private Charge.
Maine	501,793	207	330	38	56
New Hampshire	284,574	180	306	11	8
Massachusetts	737,699	471	600	173	27
Rhode Island	108,830	117	86	5	8
Connecticut	309,978	114	384	24	20
Vermont	291,948	144	254	4	9
New York	2,428,921	683	1,463	56	138
New Jersey	373,306	144	225	27	46
Pennsylvania	1,724,033	469	1,477	55	132
Delaware	78,085	22	30	7	21
Maryland	469,232	133	254	42	99
Virginia	1,239,797	317	731	58	326
North Carolina	753,419	152	428	29	192
South Carolina	594,398	91	285	16	121
Georgia	691,392	51	243	26	108
Alabama	590,756	39	193	25	100
Mississippi	375,651	14	102	16	66
Louisiana	352,411	6	49	7	38
Tennessee	829,210	103	596	28	124
Kentucky	779,828	305	490	48	132
Ohio	1,519,467	363	832	62	103
Indiana	685,866	110	377	28	47
Illinois	476,183	36	177	14	65
Missouri	383,702	42	160	18	50
Arkansas	97,574	9	36	8	13
Michigan	212,267	2	37	5	21
Florida	54,477	1	9	0	12
Wisconsin	30,945	1	7	0	3
Iowa	43,112	2	5	0	4
District of Columbia	43,712	1	13	3	4
Total	17,062,566	4,329	10,179	833	2,093

Concerning the correctness of the census figures of 1840 as given above Dr. E. Jarvis states:[1] "The American Statistical Society, in 1845, first analyzed the census of 1840, and then prepared a long memorial to Congress. In their petition they set forth the errors, inconsistencies, contradictions and falsehoods of that document, and asked Congress to disavow the whole, and cause another and correct one to be prepared and published. This

[1] Journal of Insanity, Vol. 8, p. 269.

memorial was presented to both houses of Congress, and referred to separate committees in each. . . . These errors of statement seem to be the greatest in regard to the insanity of the colored population of the Northern states. Fortunately, besides the disagreements of the several copies of the reports with each other, the document itself furnishes its own refutation. One statement contradicts another statement and shows its error."

It can be safely stated that the fifth census of 1840 is absolutely worthless as regards any correct enumeration of cases of insanity and idiocy.

In the 20th report of the Prison Discipline Society for 1845, page 7, it is stated that:

"In the United States there are 20,000 lunatics. In 18 states and 26 asylums provision has been made for about 4125 lunatics."

At each general decennial census of the population from 1850 to 1890, inclusive, the attempt was made to secure a complete enumeration of the insane by inserting on the general population schedule a question as to insanity. The question in the form in which it appeared specified insanity as one of a number of defects which were to be reported wherever found to exist. In 1850 and in 1860 the question read "whether deaf and dumb, blind, insane, idiotic, pauper or convict." And in 1870 it was the same, with the omission of "pauper or convict." In 1880, however, insanity and each of the other defects specified were covered by a separate question; but in 1890 the question again became general and comprehensive—"whether defective in mind, sight, deformed, with name of defect."[1]

Previous to 1880 the census enumeration of the insane in the United States was more or less incomplete. Indeed, the resulting statistics have been characterized as "entirely worthless so far as the calculation of ratios of number of insane to population is concerned, since the number of insane returned in these censuses was certainly less than half the number actually present."[2]

At the tenth census, 1880, the returns of the enumerators were supplemented by special schedules filled out by physicians, who reported about 17 per cent of the total number of insane accounted

[1] "Insane and Feeble-minded in Institutions, 1910," Bureau of Census. Washington, D. C., 1914, p. 11.

[2] Report on the insane, etc., Eleventh Census, 1890, p. 7.

for in that year. The co-operation rendered by medical practitioners was much less in some states than in others, and resulted in certain instances in misleading ratios. This method of enumeration was not pursued in the 11th census, taken in 1890, but the population enumerators counted as before all of the insane coming within their knowledge, whether found in or outside of institutions.[1]

The attempt to secure a complete enumeration of the insane in connection with the general population census was not repeated at the twelfth census, which was taken in 1900. Instead there was a special census of the insane taken in 1904, which, like the succeeding one in 1910, was restricted to the insane in institutions. The postponement of the inquiry, however, involved this disadvantage, that it interfered with direct comparisons between the number of insane and the general population as classified by race, nativity, age, etc. Accordingly the report for 1904 did not show any ratios except the ratios of the total number of insane enumerated in 1904 to the total *estimated* population for the same year.

The following table[2] shows the number of insane persons enumerated at each census from 1850 to 1910, those in institutions for the insane and outside such institutions being shown separately for the censuses of 1880 and 1890:

Year.	Insane enumerated in institutions for the insane.		Insane enumerated outside such institutions.		Total insane enumerated.	
	Number.	Per 100,000 population.	Number.	Per 100,000 population.	Number.	Per 100,000 population.
1910	187,791	204.2	*	*	187,791	204.2
1904	150,151	183.6	*	*	150,151	183.6
1890	74,028	118.2	32,457	51.8	106,485	170.0
1880	40,942	81.06	51,017	101.7	91,959	183.3
1870	†	.....	†	.....	‡ 37,432	‡ 97.1
1860	†	.....	†	.....	‡ 24,042	‡ 76.5
1850	†	....	†	.....	‡ 15,610	‡ 67.3

* No enumeration of insane outside of institutions.
† Included in the enumeration, but not returned separately.
‡ Enumeration believed to have been seriously deficient.

[1] Special reports, insane and feeble-minded in hospitals and institutions, 1904, Bureau of Census, John Koren, expert special agent, p. 3.

[2] This table is taken from "Insane and Feeble-minded in Institutions, 1910," p. 12, Bureau of Census, Washington, D. C., 1914.

It is not to be supposed that the very marked increase in the number of insane reported in 1880 as compared with the preceding census measures an increase in the actual amount of insanity. It can only be accounted for by the improvement in the efficiency of the canvass in 1880, as already noted.

In 1890 there was no supplementary canvass through the agency of physicians as in 1880. At the census of 1880, 183.3 insane persons were reported for each 100,000 inhabitants, but in 1890 the ratio fell to 170 per 100,000. It is safe to say that this decline in the ratio did not represent an actual decline in insanity, but, as stated in the report of 1890, is attributable to the difference in the completeness of the enumeration.[1]

As already noted, the census of 1890 was the last one at which the attempt was made to secure a complete enumeration of the insane, the census of 1904 and 1910 being confined to the insane in institutions. At the censuses prior to 1880, on the other hand, the number of insane in institutions or hospitals for this class of the population was not reported separately, so that comparisons of the growth of this class of the insane population can be made only for the thirty-year period, 1880-1910. Of the total insane population enumerated in 1880, 40,942 were reported as in institutions or hospitals, representing a ratio of 81.6 per 100,000 population; by 1910 the number in institutions had increased to 187,791, a ratio of 204.2 per 100,000 population.[2]

It is not probable that the enumeration of inmates of special institutions for the insane has been greatly defective at any census.[3]

In 1880 the ratio of the insane was 183.3 per 100,000 of the population. In 1910, as already noted, the insane in hospitals alone represented a ratio of 204.3 per 100,000 population.

At the same time it is practically certain that insanity has not increased to anything like the extent which a comparison of the different census enumerators would indicate. The extension of the practice of placing the insane under institutional care has had a very great influence upon statistics.

Other influences have likewise contributed to the apparent increase of insanity, or to the increase in the number of recognized

[1] "Insane in Hospitals, etc." Bureau of Census, 1914, p. 13.
[2] *Ibid.* [3] *Ibid.*

and recorded cases. Among these may be mentioned: Increasing average length of life, bringing more people to the "insanity age" periods; advances in diagnostic methods in psychiatry, leading to detection of mental factors in physical cases; the establishment of dispensaries; the provision of "voluntary" and emergency commitment; and better means of transportation, making it possible to bring to the hospital cases in poor physical condition.[1]

The appended Table A gives the enumeration by states of the total number of insane at each census from 1850 to 1890 inclusive, with the ratio per 100,000 of population.

The appended Table B gives the enumeration by states of the insane in hospitals at each census from 1880 to 1890 inclusive, with the ratio per 100,000 of population.

Appendix C is inserted as being of interest in connection with the preceding census tables.

[1] *Ibid.*, p. 14.

APPENDIX A.

TOTAL NUMBER OF INSANE ENUMERATED AT EACH CENSUS FROM 1850 TO 1890, AND THE RATIOS PER 100,000 POPULATION.*

Total Number.	1890.	Per 100,000 population.	1880.	Per 100,000 population.	1870.	Per 100,000 population.	1860.	Per 100,000 population.	1850.	Per 100,000 population.
United States	106,485	170.0	91,959	183.3	37,432	97.1	24,042	76.5	15,610	67.3
Maine	1,299	196.5	1,542	237.6	792	126.3	704	112.1	561	96.2
New Hampshire	961	255.2	1,056	304.3	548	172.2	506	155.2	378	118.9
Vermont	823	247.6	1,015	305.5	721	218.1	693	219.9	560	178.3
Massachusetts	6,103	276.2	5,127	287.5	2,662	182.7	2,105	171.0	1,680	168.9
Rhode Island	795	230.1	684	247.3	312	143.5	288	164.9	217	147.0
Connecticut	2,056	275.5	1,723	276.7	772	143.6	331	71.9	470	126.7
New York	17,846	297.5	14,055	276.5	6,353	144.9	4,317	111.2	2,521	81.4
New Jersey	3,163	218.9	2,405	212.6	918	101.3	589	87.6	379	77.4
Pennsylvania	8,482	161.3	8,304	193.9	3,895	110.6	2,760	95.0	1,914	82.8
Delaware	197	116.9	198	135.0	65	51.9	60	53.5	68	74.3
Maryland	1,646	157.9	1,857	198.7	733	93.9	560	81.5	546	93.7
Dist. of Columbia	1,578	684.9	938	528.1	479	363.7	204	271.7	23	44.5
Virginia	2,407	145.4	2,411	159.4	1,125	91.8	†1,179	73.9	†970	68.2
West Virginia	1,079	141.5	982	158.8	374	84.6	......	....	......	....
North Carolina	1,725	106.6	2,028	144.9	779	72.7	660	66.5	510	58.7
South Carolina	912	79.2	1,112	111.7	333	47.2	317	45.0	249	37.3
Georgia	1,815	98.8	1,697	110.0	634	53.5	491	46.4	324	35.8
Florida	351	89.7	253	93.8	29	15.4	25	17.8	11	12.6
Ohio	7,600	207.0	7,286	227.8	3,414	128.1	2,293	98.0	1,317	66.5
Indiana	3,291	150.1	3,548	179.3	1,504	89.5	1,035	76.6	563	57.0
Illinois	6,641	173.6	5,134	166.7	1,652	64.0	683	39.9	238	28.0
Michigan	3,725	177.9	2,796	170.8	814	68.7	250	33.4	133	33.4
Wisconsin	3,513	208.3	2,526	192.0	846	80.2	283	36.5	54	17.7
Minnesota	2,205	169.4	1,145	146.6	302	68.7	25	14.5	1	16.5
Iowa	3,197	167.2	2,544	156.6	742	62.1	201	29.8	42	21.9
Missouri	3,418	127.6	3,310	152.6	1,263	73.4	770	65.1	262	38.4
North Dakota	221	121.0	§	....	‡	....	......	....	......	....
South Dakota	310	94.3	§72	53.2	‡ 3	21.2	......	....	......	....
Nebraska	932	88.0	450	99.5	28	22.8	5	17.3	......	....
Kansas	1,794	125.7	1,000	100.4	131	35.9	10	9.3	......	....
Kentucky	2,729	146.8	2,784	168.9	1,245	94.2	623	53.9	527	53.6
Tennessee	1,845	104.4	2,404	155.9	925	73.5	640	57.7	407	40.6
Alabama	1,469	97.1	1,521	120.5	555	55.6	257	26.7	233	30.2
Mississippi	1,104	85.6	1,147	101.4	245	29.6	272	34.4	129	21.3
Louisiana	910	81.4	1,002	106.6	451	62.0	169	23.9	200	28.6
Texas	1,670	74.7	1,564	98.3	270	33.0	125	20.7	37	17.4
Oklahoma	7	11.3	......	....	......	....	......	....	......	....
Arkansas	790	70.0	789	98.3	161	33.2	87	20.0	63	.30
Montana	192	145.3	59	150.6	2	9.7	......	....	......	....
Wyoming	40	65.9	4	19.2	......	....	......	....	......	....
Colorado	326	79.1	99	50.9	12	30.1	......	....	......	....
New Mexico	66	43.0	153	127.9	50	54.4	28	29.9	11	17.9
Arizona	64	107.3	21	51.9	1	10.4	......	....	......	....
Utah	166	79.8	151	104.9	25	28.8	15	37.2	5	43.9
Nevada	183	399.9	31	49.7	2	4.7	......	....	......	....
Idaho	83	98.4	16	49.0	1	6.7	......	....	......	....
Washington	380	108.8	135	179.7	23	96.0	3	25.9	......	....
Oregon	640	204.0	378	216.3	122	134.2	23	43.8	5	37.6
California	3,736	309.2	2,503	289.5	1,146	204.5	456	120.0	2	2.2

* Compiled from the Reports of the Eleventh Census, 1890.

† Including West Virginia. ‡ See South Dakota. § Dakota Territory.

APPENDIX B.

NUMBER OF INSANE ENUMERATED IN HOSPITALS AT EACH CENSUS FROM 1880 TO 1910 INCLUSIVE, WITH THE RATIOS PER 100,000 OF THE GENERAL POPULATION.*

The ratio per 100,000 of population for the year 1904 is figured on the estimated population for that year only.

Division and State.	Jan. 1, 1910.		Jan. 1, 1904.		June 1, 1890.		June 1, 1880.	
	Number.	Per 100,000 population.	Number.	Per 100,000 population.	Number.	Per 100,000 population.	Number.	Per 100,000 population.
United States......	187,791	204.2	150,151	183.6	74,028	118.2	40,942	81.06
Geographic Divisions.								
New England......	19,580	298.8	14,855	250.1	7,693	163.7	5,294	132.0
Middle Atlantic....	52,380	271.2	42,562	252.5	21,435	168.8	12,710	121.1
East North Central.	41,286	226.0	33,039	196.6	15,674	116.3	8,966	80.0
West North Central.	22,683	194.9	18,595	171.9	8,641	97.2	3,493	56.7
South Atlantic......	19,952	163.06	16,514	149.1	9,007	101.7	4,660	61.3
East South Central.	9,759	116.0	7,867	100.1	4,493	69.9	2,549	45.6
West South Central.	8,413	95.8	6,010	81.8	2,043	45.0	800	24.0
Mountain..........	3,574	135.7	2,529	125.0	858	74.2	107	16.4
Pacific............	10,204	243.4	8,180	267.2	4,184	223.6	2,363	212.0
New England.								
Maine..............	1,258	169.5	885	124.3	612	92.6	403	62.1
New Hampshire....	909	211.1	496	118.5	342	90.8	288	83.0
Vermont...........	990	278.1	887	254.8	481	144.7	454	136.6
Massachusetts......	11,601	344.6	8,679	288.4	4,054	181.1	3,085	173.0
Rhode Island.......	1,243	229.1	1,077	229.2	660	191.0	392	141.8
Connecticut........	3,579	321.1	2,831	287.9	1,544	206.9	672	107.9
Middle Atlantic.								
New York..........	31,280	343.2	26,176	329.7	13,434	224.0	8,079	158.9
New Jersey........	6,042	238.1	4,865	229.4	1,744	120.7	1,632	144.3
Pennsylvania.......	15,058	196.4	11,521	169.5	6,257	119.0	2,999	70.0
East North Central.								
Ohio...............	10,594	222.2	8,621	196.9	4,960	135.1	3,499	109.4
Indiana............	4,527	167.6	4,358	168.7	1,798	82.0	920	46.05
Illinois............	12,839	227.7	9,607	187.7	4,767	124.6	2,195	71.03
Michigan...........	6,699	238.4	5,430	211.9	2,771	132.3	1,122	68.5
Wisconsin..........	6,587	282.2	5,023	232.0	1,378	81.7	1,230	93.5
Minnesota..........	4,744	228.5	4,070	217.8	1,859	142.8	708	90.7
Iowa...............	5,377	241.7	4,385	196.7	2,030	106.2	913	56.2
Missouri...........	6,168	187.3	5,103	160.8	2,417	90.2	1,350	62.3
North Dakota......	628	108.8	446	108.1	200	109.5	} 28	20.7
South Dakota......	864	148.0	595	127.2	232	70.6		
Nebraska...........	1,990	166.9	1,536	138.1	642	60.6	175	38.7
Kansas.............	2,912	172.2	2,460	158.7	1,261	88.4	319	32.0
South Atlantic.								
Delaware..........	441	218.0	353	184.7	142	84.3	......	......
Maryland..........	3,220	248.6	2,505	204.2	1,416	135.8	912	97.5
Dist. of Columbia..	2,890	872.09	2,453	823.09	1,496	649.3	860	484.2
Virginia............	3,635	176.3	3,137	162.6	1,764	106.5	1,098	72.6
West Virginia......	1,722	141.0	1,475	139.9	860	112.7	394	63.7
North Carolina.....	2,522	114.3	1,883	93.8	972	60.1	269	19.2
South Carolina.....	1,541	101.7	1,156	82.3	664	57.7	425	42.7
Georgia............	3,132	120.0	2,839	120.4	1,491	81.1	626	40.6
Florida............	849	112.8	713	116.9	202	51.6	76	28.2

* Insane in Hospitals, etc., Bureau of the Census, 1914, page 21.

INSANE ENUMERATED IN HOSPITALS (Continued).

Division and State.	Jan. 1, 1910.		Jan. 1, 1904.		June 1, 1890.		June 1, 1880.	
	Number.	Per 100,000 population.	Number.	Per 100,000 population.	Number.	Per 100,000 population.	Number.	Per 100,000 population.
East South Central.								
Kentucky	3,538	154.5	3,058	139.1	1,991	107.1	1,404	85.2
Tennessee	2,204	100.9	1,713	82.3	806	45.6	385	25.0
Alabama	2,039	95.04	1,603	82.6	1,014	67.0	373	29.5
Mississippi	1,978	110.1	1,493	91.0	682	52.9	387	34.2
West South Central.								
Arkansas	1,092	69.4	667	47.4	390	34.6	......	......
Louisiana	2,158	130.3	1,585	107.0	608	54.4	450	47.9
Oklahoma	1,110	67.0	413	37.4	......	......	......	......
Texas	4,053	104.0	3,345	99.7	1,045	46.7	350	22.0
Mountain.								
Montana	697	185.3	543	186.3	172	130.1	44	112.4
Idaho	388	119.2	255	115.3	63	74.7	......	......
Wyoming	162	111.0	96	85.8	23	37.9	......	......
Colorado	1,199	150.1	754	119.0	239	58.0	34	17.5
New Mexico	219	66.9	113	46.5	......	......	......	......
Arizona	337	164.9	224	146.9	65	109.0	......	......
Utah	342	91.6	344	110.3	124	59.6	29	20.1
Nevada	230	280.9	200	352.8	172	375.9	......	......
Pacific.								
Washington	1,987	174.0	1,178	158.2	341	97.6	91	121.1
Oregon	1,565	232.6	1,285	253.2	554	176.6	262	149.9
California	6,652	279.8	5,717	316.0	3,289	272.2	2,010	232.5

APPENDIX C.

POPULATION OF THE COLONIES IN 1715.

New Hampshire		9,650
Massachusetts		96,000
Rhode Island		9,000
Connecticut		47,500
New York		31,000
New Jersey		22,500
Pennsylvania		45,800
Maryland		50,000
Virginia		95,000
North Carolina		11,200
South Carolina		16,750
Whites	375,750	
Blacks	58,850	
	434,600	

In Maryland in 1698 Governor Nicholson declares: "Here are no beggars; such as are superannuated are reasonably well provided for by the counties."

III.

FEEBLE-MINDED IN INSTITUTIONS.[1]

As has been noted in the previous chapter, an attempt was made to enumerate all the mentally defective in the general population in connection with the population censuses from 1850 to 1890, inclusive. On account of the different methods adopted in different years, however, the results cannot be regarded as complete or comparable. As regards the feeble-minded, the enumeration from 1850 to 1880 covered chiefly those whose idiocy or imbecility was apparent. In the report for 1890, the term "feeble-minded" was adopted to cover those on the border-line of mental deficiency, who were evidently not idiots in the ordinary acceptance of the word. Since 1890, however, no general enumeration has been attempted by the Bureau of the Census of this large and ill-defined class.

Formerly almost all of the class under institutional care were in almshouses or in asylums for the insane. In 1890 only 16 states had provided separate institutions for the feeble-minded, and the number of such institutions was only 24. In 1904 the number of states making such provision was 25, and the number of institutions 42. In 1910 there were 63 institutions reported by 31 states. In 1914 there were only 7 states which made no special provision for this class of defectives.

In the 1890 census there were 5254 feeble-minded in special institutions, and 2469 in hospitals for the insane; in addition 7811 inmates of almshouses were returned as "idiots," makng a total of 15,534 feeble-minded and idiots. In 1904 the number in special institutions was 14,347 and in 1910, 20,731. The 1904 and 1910 censuses made no special enumeration of the feeble-minded in hospitals for the insane, nor in reformatories or other correctional institutions; but the 1904 report on paupers showed 16,551 inmates of almshouses classed as feeble-minded, which number was reduced in the report of 1910 to 13,238.

[1] Compiled from "Insane and Feeble-minded in Institutions, 1910," Bureau of Census, Washington, D. C., 1914, pp. 183-184.

On January 1, 1904, therefore, there were 30,898 feeble-minded persons either in special institutions or in almshouses, and on January 1, 1910, 33,969.

According to the report of the Massachusetts State Board of Insanity for 1912, there were 5007 feeble-minded enumerated in the general population. In addition 245 were reported by overseers of the poor, making a total of 5252 not in institutions. The number in institutions was 2587, making the total number of feeble-minded in the state 7839. It is of interest to note that if the proportion of feeble-minded to the total population was the same for the entire United States as it was in Massachusetts according to this census, the total number of feeble-minded would be over 200,000. This would indicate that not one-tenth of the feeble-minded are being cared for in special institutions.

PART II

GENERAL HISTORY OF CANADA

CHAPTER XIII

GENERAL CONSIDERATIONS IN CANADA

I.

LAWS FOR THE COMMITMENT OF THE INSANE IN CANADA.

The committee has, through the kind efforts of several superintendents of Canadian institutions, succeeded in procuring copies of the laws of commitment in the following provinces: Alberta, British Columbia, Manitoba, New Brunswick, Nova Scotia, Ontario, Prince Edward Island, Quebec, Saskatchewan and Yukon Territory.

For the most part the laws of commitment seem to have been modeled upon those of older provinces, notably those of Nova Scotia and New Brunswick. It is evident, upon looking over the laws in Manitoba, Alberta, Saskatchewan and Yukon, that the provisions for the commitment of patients to institutions have been taken almost literally from the former statutes, and the laws of the newer territories show no change from practices in the older provinces. This has been largely due to the fact that at first, before institutions were established in growing provinces, no institutions existed for the care of the insane at home. It was necessary to arrange for them in the institutions of the older provinces. It was natural therefore that whenever a territory erected and organized an institution, the laws with which the officials had become familiar were generally adopted in spirit and frequently in form.

Legislation, however, in the Province of Quebec for the commitment of the insane proceeds upon somewhat different lines, and its peculiarities deserve some special notice.

In the case of private patients it is provided that they may be admitted upon certificates of insanity signed by two physicians possessing certain qualifications. These men must state facts based upon their own personal observation in giving certificates of insanity.

It is further provided that the medical superintendent of the asylum appointed by the government and representing the state shall join in the completion of a patient's admission and shall examine him within three days of his admission and forward a

report under oath to the Provincial Secretary, who shall immediately furnish a copy of it to the parish priest or minister of the place whence the patient comes, or if the patient is a foreigner, to the consul of his country. We know of no other country where the parish priest or minister is considered in the admission of a patient to an institution.

It is provided also that public patients must, in addition to certificates from two physicians, furnish certificates from a mayor or counselor or the secretary-treasurer of the municipality as to their indigence for the guidance of the Provincial Secretary, who is required to say what proportion of their expenses in the institution shall be paid by the individual or by the public.

In nearly all of the other provinces an application must be made to a justice of the peace for the commitment of a supposedly insane person to an institution.

If the patient is found to be insane an application must then be made to the superintendent of the lunatic asylum with a statement of his case in order to procure consent to bring him to the institution.

In a number of the provinces it is not lawful to transfer an insane man to a hospital without prior receipt of such consent.

The effect of such preliminaries in newly settled regions, where mails are infrequent and travel necessarily slow, must be to delay greatly the admission of patients to institutions. Evidently the provision grew out of the fact that nearly or quite all institutions were inadequate to meet the demands upon them and it was impossible to receive patients promptly whenever mental disease developed. The effect, however, of the provision has undoubtedly been to increase the list of incurable insane, most of whom remain in jails or other places of confinement, under unfavorable conditions for a long time before admission can be secured.

In two provinces only are provisions of law found for the admission of voluntary patients. In the remainder of the provinces and territories special emphasis seems to be placed upon the fact that the insane person is dangerous to be at large, little consideration being given to the need of treatment to promote recovery. It is evident that when the country becomes more thickly settled and pioneer conditions disappear there will be a more emphatic demand for the curative treatment of the curable insane.

PROVINCIAL LUNATIC ASYLUM, TORONTO, ONT., 1850. NORTH VIEW.

ALBERTA.

When information is laid before a justice of the peace that any person is suspected or believed to be insane the justice shall issue his warrant to apprehend him and cause him to be brought into court.

The justice shall then proceed to hear evidence under oath as to his insanity and the danger to be apprehended from it, his place of residence and other facts in reference to his civil condition. The justice may adjourn the inquiry from time to time and recommit the prisoner to jail until a proper inquiry has been made, but in no case shall the adjournment be for more than three days.

If after hearing the evidence the justice is satisfied that the person is insane and dangerous to be at large, he may commit him to the nearest jail or to the custody of any relative or friend to await the order of the Attorney General for his removal to an asylum or until his discharge by law.

He shall further make a report, accompanied by the evidence, to the Attorney General, who shall have power to order further inquiry to be made.

If the justice is satisfied that the person is not dangerous to be at large he shall forthwith discharge him from custody and report the proceedings to the Attorney General.

If the justice is satisfied that the person is insane and dangerous to be at large he shall inquire as to his property and whether he shall be maintained as an insane pauper or not.

The Attorney General may issue his warrant or direct the removal to an asylum of any person so committed. He may also at any time order the release of such person on trial, either temporarily or permanently.

If upon the committal of such person any relative or friend believes it to be unwarranted and not justified by the evidence, he may, on notice to the Attorney General, apply within four days to a judge of the Supreme Court for his discharge from custody on the ground that he is not insane, or if insane that he is not dangerous to be at large.

The judge shall forthwith examine the person committed as insane and the evidence and other papers, and may hear further evidence, and if satisfied that he is not insane or dangerous to be

at large he may grant a certificate for his discharge from custody, or may dismiss the application.

If any relative or friend of the patient desires to take him to an asylum and is competent to do so the warrant for such removal may be executed by a relative or friend. A female patient, unless accompanied by her father, mother, sister, brother or husband, must be placed in charge of and accompanied by a woman.

If an insane person committed to an asylum is not possessed of sufficient means or his relatives are incapable of providing the same, the cost of his maintenance and other expenses shall be defrayed by the province.

Any person now or hereafter confined in any jail as insane shall be liable for his maintenance if he becomes possessed of property.

Until the Province of Alberta has an institution of its own the asylum belonging to the Province of Manitoba shall be used.

Every person in custody by virtue of this statute shall remain in the asylum until properly discharged.

BRITISH COLUMBIA.

Hospitals for the insane are established for the custody and treatment of insane persons, and their property and effects are vested in the Crown. The Lieutenant Governor in Council makes all rules and regulations for their management and for the admission and discharge of patients.

The Lieutenant Governor in Council appoints in every public hospital for the insane a medical superintendent and such other officers and servants as are required. The medical superintendent directs the medical and moral treatment of patients. He watches over the internal management of the hospital and maintains discipline. The financial affairs of the hospital are conducted under the control and direction of the superintendent by a clerk.

The Lieutenant Governor in Council grants licenses to proprietors or occupiers of private houses to receive insane persons for care and treatment, and makes rules and regulations for the management of such houses and appoints an inspector of them. No licenses are granted until such houses are found to comply with the regulations.

Removal and Admission of Patients.—No person is committed to any hospital or institution for the insane as a lunatic except

upon an order of the Lieutenant Governor in Council, without a duly executed order signed by a judge or registrar of a court of record, or a stipendiary magistrate, or a police magistrate, or a justice of the peace, and with two certificates, in proper form, bearing date within one month prior to the day of admission, signed by two duly qualified medical practitioners in actual practice of their profession, neither of whom shall be a partner, or assistant or a near relative of the medical practitioner who signed the other certificate.

A statement signed by a near relative or friend or by a judge or other official who signed the order of admission giving the antecedents of the patient is also required. Every person thus admitted to a public or private hospital remains subject to the custody of the medical superintendent until duly discharged. No judge or other legal official and no medical practitioner who is a near relative of the patient is competent to sign the order of admission or the medical certificates in any case.

Where the admission of a patient becomes necessary under an urgency order a single medical certificate is admissible, provided that the reasons are stated and that within 14 clear days from the admission proper certificates are furnished. Where a patient has been committed to a public or private hospital under an urgency order it is the duty of the medical superintendent to give notice thereof within two clear days to the relatives or friends of a patient, if a private patient, or to the superintendent of police in case of a free patient; and the superintendent of police or relatives or friends must procure the order or certificates required by law within 14 days.

The superintendent may refuse to admit a patient under an urgency order if in his judgment the reasons are not sufficient.

Committal of Dangerous Lunatics.—If information is laid before any magistrate that a person within his jurisdiction is believed to be insane and dangerous to be at large, the magistrate may issue a warrant for his arrest. This warrant states that information has been laid under oath that the person is insane and dangerous to be at large. The person alleged to be insane is brought before the magistrate, who commits him to a common jail or prison or to the custody of the constable or to such other safe custody as the magistrate deems fit. But he shall not be

committed beyond three days without a hearing, and at the hearing the magistrate shall hear evidence under oath as to the alleged insanity of the person and may adjourn the hearing from time to time until a proper inquiry is made.

If the magistrate is satisfied that the prisoner is insane and dangerous to be at large he may commit him to the common jail or lock-up, there to remain until duly committed to a public hospital for the insane or discharged by law.

No lunatic or other person of unsound mind not convicted of crime shall be confined in a jail or lock-up or any other place of confinement in the same room with any person charged with or convicted of crime. If a female is detained in any jail or lock-up as a lunatic the services of a female attendant must be secured to take charge of her during her detention. If a female patient is conveyed to a public or private hospital, unless accompanied by her father, mother, son, brother or husband, she must be placed in charge of and accompanied by a female.

Insane Convicts.—The Lieutenant Governor in Council may order the removal of any person found to be insane and under imprisonment to a public hospital, there to remain until his discharge is justified.

Discharge on Probation.—If the medical superintendent of any public hospital for the insane considers it conducive to the recovery of any patient to commit him to the care of his friends he may allow him to return on probation to them upon receiving a written undertaking by one or more of his friends to keep an oversight over him. If within six months the insane person again becomes dangerous to be at large it is lawful for the medical superintendent to direct any constable or peace officer to apprehend and return him to the hospital for the insane.

The proprietor or superintendent of any private hospital may commit a patient to the care of his friends and if he becomes dangerous the officers or servants of the private hospital may retake him and bring him back to the hospital without a new order or commitment.

If an inmate of a hospital escapes the medical superintendent may issue a warrant for his return and any officer or servant of the hospital may, in addition, retake such person without a warrant within 48 hours, and within two months after such escape with a warrant.

PROVINCIAL LUNATIC ASYLUM, TORONTO, ONT., 1850. SOUTH VIEW.

In case an inmate of a private hospital escapes it shall be lawful for any officer or servant to retake the escaped person within 28 days and he shall remain in custody by virtue of the authority by which he was detained originally.

Maintenance of Patients.—Before a private patient can be admitted to any public hospital a bond must be executed to secure proper payment of such amount as may be agreed upon for the patient's maintenance. In the case of an insane person sent to any public hospital who is under 21 years of age and has a father, or mother or guardian liable to maintain him, the medical superintendent may send a copy of the order to the father or mother or guardian with a statement of the amount due for him each month, and shall also render an account for maintenance and clothing with a demand for the payment of the same.

Penalties.—Any proprietor, manager, officer, nurse or any other person who ill treats or willfully neglects a patient shall, on summary conviction, be liable to a penalty not to exceed $100 with costs or to imprisonment or to fine and imprisonment with or without hard labor. If a person receives or detains an insane person in an unlicensed house he shall be liable to a fine of $200 and costs or to imprisonment for a term not to exceed six months, with or without hard labor.

If the keeper of a jail or lock-up illegally detains any person on the ground of insanity contrary to the provisions of this act he shall be liable to a penalty not to exceed $200, with costs, or to imprisonment for any term not to exceed six months, with or without hard labor.

MANITOBA.

Whenever information is laid before one of the justices of the peace that a person within his jurisdiction is suspected or believed to be insane and dangerous to be at large, and has shown a purpose of committing some crime for which he would be liable to be indicted, or is likely to do bodily harm to himself, the justice may issue a warrant for his apprehension. Each warrant under the hand and seal of the justice or justices shall order the person to whom it is directed to bring the insane person before a justice to make inquiry respecting his sanity. Pending such investigation the justice may commit him to jail or to the constable.

Upon the day appointed the justice proceeds to hear evidence in reference to his alleged insanity and directs inquiry to be made as to his relatives or friends, that they may be communicated with or evidence may be had as to his previous habits.

The inquiry may be adjourned from time to time, but no adjournment shall be for more than three days.

If a justice is satisfied that the person is insane and dangerous to be at large he may commit him under his warrant to the common jail of the district until he be removed to an asylum or discharged according to law. Or if, in the opinion of the justice, he should not be committed to the common jail, he may be committed to the custody of any relative or friend to await the order of the Attorney General to have him removed to an asylum.

If it appears to the justice or justices that the person is not insane or is not dangerous to be at large, then the justice shall discharge him from custody.

It becomes the duty of the justice to make inquiry as to whether the prisoner is possessed of property and where it is situated; also the number of persons dependent upon him for support, in order to ascertain whether or not he shall be supported as an insane pauper.

The Attorney General may order the removal from the jail to an asylum of any person confined in a jail as above. But no such person shall be committed to an asylum unless two legally qualified medical practitioners have each, separately from the other, personally examined him and certified that he is insane.

Discharge.—Any judge of the King's bench of the county court may, on application, certify that he has personally examined a person thus committed and that in his opinion he is not dangerous to be at large and is not a proper person to be confined in an asylum. Or two legally qualified medical practitioners may certify in like manner, and such person shall forthwith be discharged by the keeper of the jail, and such certificates shall be sufficient authority for his doing so.

Any person in any asylum in the Province of Manitoba shall remain subject to the custody of the officers and other persons in charge of such asylum until discharged under the provisions of this act.

If any relative or friend of a patient committed to an asylum desires to take him to such asylum and is competent to do so, the warrant for commitment may be delivered to him instead of to an officer. No person of unsound mind shall be confined in a jail or lock-up in the same room with a person charged with or convicted of any crime.

Every person detained in an asylum shall be discharged as soon as, in the opinion of the superintendent, he is restored to reason or is competent to act for himself.

A patient may be removed from an asylum with the consent of the superintendent by his relatives or friends if the superintendent considers that they are able to take proper care of him, and the superintendent may require them to give sufficient security for his proper care and maintenance.

A patient not recovered may be discharged upon the certificate of the superintendent that he is harmless and will probably continue so and is not likely to be improved by further treatment in an asylum; but he shall first notify the person or persons at whose instance the patient is detained, and unless they within two weeks furnish satisfactory proof of the necessity for further treatment the patient shall be discharged.

In case the superintendent of an asylum considers it conducive to the recovery of any person that he be committed for a time to the custody of his friends the superintendent may allow him to be returned on trial to them, upon receiving a written undertaking by one or more of them that they will keep an oversight over him. These provisions do not authorize the temporary discharge of any person who has been imprisoned for an offence, whose period of sentence has not expired.

If within a period of six months from such temporary discharge on trial an insane person again becomes dangerous to be at large or requires treatment in an asylum, it shall be lawful for the superintendent to authorize and direct that he be apprehended and returned to the asylum.

Only legally qualified practitioners are qualified to grant medical certificates under this act.

It is provided that no insane person shall be confined in any jail except there is lack of accommodation in an asylum, and then only with the consent of the Attorney General.

NEW BRUNSWICK.

Prior to the admission of any patient to the provincial hospital a permit must be received from the medical superintendent. To procure this medical certificates must be filed with the superintendent from physicians duly registered in the Province of New Brunswick, certifying after an examination that the person is insane and needs care and treatment, and that the opinion has been formed on facts indicating insanity observed at the time of the examination. Accompanying such certificate shall be a history giving as full details as may be acquired concerning the patient. In addition there shall be a certificate from the clerk of the town or city or the secretary of the county from which the patient is to be sent, also from the nearest of kin of the patient as to whether he has sufficient estate to support him in the hospital while under treatment. If two physicians' certificates are used they must be furnished by physicians who do not bear the relation of partners, brothers, father or son to each other.

The friends of a patient may have the medical examination made and procure the necessary certificates, and, if a permit to enter the hospital is issued, defray the expenses connected with conveying the patient to the hospital. If, however, they cannot do so, application should be made to a municipal officer to authorize a medical examination and the preparation of the certificate, in which case the municipality shall pay the physician's fees and the cost of transportation. If a municipality pays these expenses it can recover them from the relatives or those liable for his support.

If a patient has no friends or they decline to act, two ratepayers may make application to a municipal officer for the medical examination. Any person who knowingly or willfully makes or joins in making or advises the making of a false certificate whereby a sane or insane person is committed to the hospital or whereby any insane person is sought to be made a public charge, shall be liable to a penalty not to exceed $200, and if a physician, he shall be deprived of the right to practice his profession for a period of one year.

Patients whose friends are able to pay the entire cost of maintenance may be granted admission to the hospital on two certificates of physicians, without certificates from the clerk or municipal officer or a certificate from the nearest of kin.

A fee of $20 is imperative upon admission in all cases admitted, and if not paid when the patient is brought to the hospital the treasurer of the municipality may be required to pay it by the medical superintendent.

When a female patient cannot be accompanied by a relative a woman must come with her.

NOVA SCOTIA.

An application for admission is made by the nearest relations or friends to the medical superintendent of the hospital, upon a prescribed blank, giving a full history of the patient's mental disease and the circumstances of his attack. This is sworn to before a justice of the peace and executed within a period of 14 days subsequent to the last interview with the patient.

No patient can be admitted unless a reply to this application has been received from the medical superintendent enclosing an order for admission.

Two medical certificates are presented, executed by medical practitioners duly qualified in Nova Scotia and authorized to execute such a certificate. These certificates are dated within 14 days of the commitment and must be the result of a personal examination. The second certificate cannot be signed by the father, brother, son or assistant of the medical practitioner who signed the first certificate. An order shall be granted by the Commissioner of Public Works and Mines for the admission of the patient to the hospital, provided he is not idiotic or epileptic (even if insane though not violently insane), or is not suicidal or dangerous to the life and property of others, or a person of long standing insanity who is not likely to be benefited by hospital treatment.

The medical certificates and orders of admission are sufficient authority for any person to convey a patient to the hospital and equal authority to the medical superintendent of the hospital to retain him under treatment until he is duly discharged.

Patients found wandering at large and about whom nothing is known, or who have been previously under care in the county asylum, cannot be received or detained in the hospital except under a special warrant.

There are county asylums in the provinces to which acute cases may be admitted only for care pending arrangements for their admission to the Nova Scotia Hospital. Cases of long standing may be admitted directly to county institutions on certificates similar to those required for the Nova Scotia Hospital, but a warrant must be sent by a stipendiary magistrate or a justice of the peace. A patient thus committed to a county asylum may be subsequently sent to the Nova Scotia Hospital upon the certificates under which he was committed to the county asylum, but a new warrant is required.

In cases which are urgent or in violent cases where, from information furnished, the superintendent believes a delay in admission may be injurious to the patient, he may authorize him to be forwarded to the hospital without a statement of particulars, but medical certificates and warrant (when warrant is required) shall be forwarded with the patient to the medical superintendent.

The following provision is made for the admission of voluntary patients:

The commissioner, on the recommendation of the medical superintendent, may grant an order for the admission to the hospital as a voluntary patient of any person who is desirous of submitting himself to treatment, and who makes written application therefor, and whose mental condition is such as to render him competent to make such application. Such person shall not be detained for more than three days after having given notice in writing of his intention to leave the hospital. All provisions of this chapter as to maintenance of patients shall apply to such voluntary patients.

ONTARIO.

Admission of Patients.—No person except a voluntary patient can be admitted to a hospital for the insane without the certificates of two legally qualified medical practitioners, accompanied by the family and financial history in the prescribed form and upon notice from the superintendent of the hospital that a vacancy exists. Each certificate shall state that the patient was personally examined by the medical practitioner; the facts upon which he formed his opinion must be stated and facts learned from other persons must be indicated. Each certificate shall be signed in the presence of two subscribing witnesses and bear date within three months of the admission of the patient.

Patients in indigent circumstances who are proper subjects for hospital treatment may be examined at the expense of the municipality, provided that the head of the municipality is satisfied that they are in destitute circumstances.

Admissions of Voluntary Patients.—The superintendent of the hospital may receive and detain any person suitable for care and treatment who voluntarily makes written application and whose mental condition is such as to render him competent to do so. He shall not be detained more than five days after he has given notice in writing of his desire to leave the hospital. Within three days after his admission the superintendent shall transmit to the inspector his clinical record; he shall also transmit, on the first day of each month, the names of all voluntary patients in the hospital.

Admission of Dangerous Patients.—Upon information laid before him any justice of the peace may issue a warrant to apprehend any insane person alleged to be dangerous to be at large.

Any apparently insane person conducting himself in a disorderly manner may be arrested without warrant by any peace officer and detained in some safe and comfortable place, not a jail, lock-up or reformatory, until the question of his insanity may be determined.

Immediately upon the arrest of such person he shall be examined by one or more legally qualified medical practitioners appointed for the purpose, and the justice shall also hold a hearing, in addition to the examination, and receive testimony on oath from friends or relations or any person acquainted with the circumstances of the case. If the medical practitioners do not agree they may examine the alleged insane person again within a week and give new certificates if they change their opinions as to his insanity. If he is found not to be insane he shall be discharged. If, however, the patient is found to be insane and dangerous to be at large the justice shall transmit the evidence to the inspector, who shall arrange for his admission to a hospital and issue his warrant for his transfer thereto.

If a person so certified by the justice to be insane is not in destitute circumstances the expenses of his examination may be recovered from his estate or the persons liable for his maintenance.

Insane Prisoners.—The Lieutenant Governor, upon evidence of the insanity of any person in any prison other than a penitentiary, may by his warrant order his removal to a place of safekeeping until such time as a certificate is given of his complete or partial recovery. The Lieutenant Governor may then issue an order for his reimprisonment or may otherwise discharge him.

Discharge of Patients.—All persons admitted to a hospital by a warrant from the Lieutenant Governor may be discharged by the Lieutenant Governor, by the inspector or the superintendent of the hospital.

Escapes and Recommittals.—A patient escaped from a hospital may be arrested by the officer or any servant of the hospital without a warrant within 48 hours after such escape; also within one month after such escape upon a warrant from the superintendent. The superintendent, whenever he believes it conducive to the recovery of a patient, may commit him to the custody of his friends upon receiving a written undertaking by one or more of them to take care of him. This action does not apply to persons in prison for an offence. If within six months such temporarily discharged person becomes dangerous the superintendent may authorize and direct a constable or peace officer or any other person to return him to the hospital.

Maintenance of Patients.—If a patient in a hospital be under age and has a father and mother or a guardian able to pay for his maintenance, the bursar of the hospital is authorized to send a written notice of the amount to become due for his maintenance quarterly. If the payment of this sum is refused the inspector may apply to the judge of the county or district court for an order for such payment. If the judge is satisfied that the person against whom the application is made is liable he may make an order accordingly. The inspector may also recover such sum due for maintenance, but he shall not enforce payment until after inquiry as to the claims of the patient to be maintained by the person liable.

If property has been received by the inspector and the Lieutenant Governor authorizes him to do so he may pay to any member of the family of such patient such amount as may be deemed proper. Each gift, claim, alienation, conveyance or transfer of property of any person who is or becomes an inmate of the hos-

pital shall be deemed void and fraudulent as against the inspector, if the same has not been made for full and valuable consideration actually placed.

QUEBEC.

All lunatic asylums in the province which have received grants from the government are under its control; all other asylums are under its supervision only. The Lieutenant Governor appoints a medical superintendent for each asylum under a contract with the government; he also appoints in addition an assistant medical superintendent and two house physicians for the three asylums, known as St. Jean de Dieu, Verdun and Beauport.

The Duties of the Medical Superintendent.—The medical superintendent supervises the admission and discharge of patients.

He controls the medical service, the classification of patients and their treatment.

He makes an annual report to the Provincial Secretary respecting the patients under his care.

He formulates all rules and regulations for the medical, moral and physical treatment of patients.

He requires proprietors to dismiss nurses or guardians for incompetence or insubordination.

Assistant Medical Superintendents and House Physicians.—The assistant medical superintendent exercises the powers of the superintendent in event of his absence or inability to act. The house physicians devote their whole time to the service of their patients. They reside near the asylum. They prescribe the treatment, medical and moral, approved by the medical superintendent and execute all rules and regulations.

Private Patients.—Patients are admitted to lunatic asylums upon certificates that they are insane signed by two physicians who are not medical partners, nor brothers, nor in relation of father and son to each other, to the proprietors of the asylum or to the patient. They must specify in their certificates such facts as have come under their own personal observation.

The medical superintendent examines each patient within three days of his admission and forwards a report under oath to the Provincial Secretary, who immediately furnishes a copy to the parish priest or minister of the place whence the patient comes, or, if he is a foreigner, to the consul of his country. If there is

opposition to the confinement of such patient, application is made for his discharge to a judge of the Superior Court of the district. The judge may refer the matter to the judge of the district from which the patient comes or he may order the discharge. The medical superintendent is required to forward every month to the Provincial Secretary the name of each private patient admitted or discharged, also the date of admission or discharge, the names of persons applying for his admission or discharge, the names of the two physicians who certified as to his insanity, and the date of his escape, death or discharge.

Public Patients.—The following persons may be admitted to lunatic asylums at the expense of the government and of cities, towns and counties:

1. Persons who cannot from their own property or through some person compelled by law to support them pay fully or in part the expense of custody, maintenance or treatment in an asylum.

2. Idiots or imbecile persons who are dangerous or a source of scandal or subject to epilepsy and are unable to pay for custody, maintenance or treatment.

No patient can be admitted unless there be presented to the medical superintendent of the asylum an application signed by relatives, friends or protectors attested before a public officer, physicians' certificates of insanity from physicians of the same qualifications as those prescribed for private patients, and certificates from a mayor, or councillor or secretary-treasurer of the municipality, attested before a public officer.

If a portion of the maintenance of the patient is to be paid by relatives the Provincial Secretary shall decide what portion it shall be.

The medical superintendent shall furnish a permit for the admission of the patient and no patient shall be brought without it. In case of an emergency the medical superintendent may dispense with a physician's certificate, which must, however, be furnished within eight days. Certificates of physicians shall be void unless executed within a period of not more than 20 days prior to being sent to the medical superintendent.

The medical superintendent or his assistants may at all times give a written authorization to admit a relative, friend or physician

to visit a patient. Every letter written by a patient, addressed to members of the executive council, the inspector of the asylum, the family of the patient or those who obtained his confinement, shall be forwarded unopened to its address.

Every person related or allied to a patient in an asylum may obtain his release by an application to the medical superintendent and by binding himself to take care of him, provided that the superintendent is of the opinion that the patient may be set at liberty without danger.

If an insane patient dies in an asylum the proprietors must notify the medical superintendent and furnish all necessary information.

Insane People in Jails.—Upon application and a proper certificate of insanity from the superintendent of an asylum for the insane or any physician appointed by the Provincial Secretary, a person confined in a jail for any offence may be transferred to an asylum upon an order from the Lieutenant Governor. The proprietors of each asylum are required to furnish a list of the names of all persons confined in an asylum who have been transferred from a jail. Upon report of the medical superintendent or of his assistants that an insane person confined in an asylum under authority of the criminal code has recovered, the Lieutenant Governor shall order him to be discharged altogether or reconveyed to jail to stand trial or to undergo sentence.

Dangerous Lunatics.—Dangerous lunatics may be confined in an asylum under order of a recorder or police magistrate or upon the sworn information of two tax payers that the person endangers public safety, decency and peace, accompanied by physicians' certificates according to regular form.

Escaped Patients.—If a patient escapes from an asylum each officer may apprehend him or cause him to be apprehended and brought back without any warrant or within three months under a warrant issued by the medical superintendent or assistant.

Discharged Patients.—A medical superintendent may discharge a patient on trial upon the written promise of a relative or friend to take care of him and to bring him back if he becomes dangerous. No person shall be detained after his cure has been established by the medical superintendent and an order given for his discharge. Any person detained in an asylum may at any time

apply to the judge of the district for his discharge from the asylum. The judge after proof may order such discharge and his decision shall be final and without appeal.

PRINCE EDWARD ISLAND.

Prior to the admission of any patient to an asylum it is necessary to secure a certificate from a regularly qualified physician of the province as to his insanity, also a statement giving a history of his case to be sent to the medical superintendent for examination; and the answer and approval of the medical superintendent shall be received before the patient is forwarded. The practitioner must be in actual practice in the province and the examination must be made during a period of not more than 30 days before the application for his admission.

If the patient is possessed of means a bond must be executed binding the signer to pay a weekly sum for the maintenance of the patient while in the hospital. If he has no means the patient must be received upon a pauper's affidavit with an admission fee of $10 or upon an order from the trustees granting free admission. What is known as a pauper's certificate shall be sworn to by the applicant before a justice of the peace and two justices of the peace must certify that the affidavit is correct. The law seems to be defective in that it makes no provision for a medical examination or certificate or an order from a judge in case of a pauper patient, but provides that the order from the trustees granting free admission shall be sufficient.

Criminal Patients.—Criminal cases are admitted upon a warrant from the Lieutenant Governor.

YUKON TERRITORY.

If information is laid before a justice of the peace that any person is insane or supposed or believed to be, he shall issue a warrant to apprehend the person and cause him to be brought before him. The justice shall then proceed to hear evidence as to his insanity and to ascertain his residence, his profession, his means of support and his civil condition, as to whether, if he is committed as insane, he should be sent back to his former residence and at whose cost. If after hearing the evidence the justice is satisfied that he is insane, he shall commit him by war-

rant to jail, there to remain until the pleasure of the commissioner of the Yukon Territory is known or until he is discharged by law. If it appears that the person is not insane the justice shall discharge him. The justice may compel the attendance of witnesses in making the investigations.

Removal of Insane Persons in Custody by Order of the Lieutenant Governor.—Whenever under any law or ordinance an insane person is kept in custody until the pleasure of the Lieutenant Governor is known or until such person is discharged by law, the Lieutenant Governor may cause him to be removed to and confined in any asylum or place of confinement from time to time designated for that purpose by the Governor in Council, and the superintendent or warden of such asylum or place of confinement shall receive him and detain him therein until the pleasure of the Lieutenant Governor is known or until he is discharged by law.

Persons adjudged to be insane in Yukon Territory are, by warrant of the commissioner, removed to and confined in the provincial asylum of the Province of British Columbia at New Westminster, such being the asylum or place of confinement designated for that purpose by the Lieutenant Governor.

NEWFOUNDLAND.

Commitment of Insane.—Patients are admitted on an order from a stipendiary magistrate upon an application in writing, or upon a warrant if found dangerous to be at large. Such order must bear date within 14 days prior to the reception of such persons and be accompanied by certificates of two qualified medical practitioners. The magistrate must cause a full and particular inquiry to be made into the sanity of the alleged lunatic, which inquiry may be *ex parte*. If the magistrate is satisfied from the medical and other testimony that he is a proper person to be confined in the asylum, he shall grant an order for his reception and detention. The expense of the inquiry and of conveying him to the asylum, when a pauper, is a charge on the Commissioner of Public Charities.

In case of emergency the superintendent of the asylum may receive and detain any person as a lunatic for a period not exceeding three days, on a certificate of one duly qualified medical practitioner.

II.

CARE OF THE INSANE IN CANADA PREVIOUS TO THE ESTABLISHMENT OF PROVINCIAL INSTITUTIONS.

We learn from Dr. T. J. W. Burgess[1] that "in 1639 the Duchess d'Aiguillon, niece of Cardinal Richelieu, founded the Hotel Dieu of Quebec for the care of indigent patients, the crippled and idiots.[2] Four years later, namely, in 1643, Mademoiselle Mance founded the Hotel Dieu of Montreal.

An ordinance of the 15th of October, 1663, reproduced in the "Judgments and Deliberations of the Royal Council," directed that "all sick persons" must be returned to France as soon as possible. This no doubt included the insane. A mention of an asylum, to be situated in Canada, is found in the "Letters Patent" granted in April, 1694, to Sister Charon de la Barre, by which authority was granted her to establish a "Home," which would include the insane of Montreal. In 1747 this "Home" was entrusted to the Venerable Widow Youville, with the direct request from the Sulpician Fathers that the insane be included. This request is in the archives of the Grey Nuns at Montreal.[3] This would indicate that the first care of the insane in North America was undertaken by the religious bodies of New France, now Quebec.

No records are available as regards the measure of care meted out to the victims of mental disease confined in the "Home" under the care of the Venerable Widow Youville, but from the histories of subsequent institutions of like character we know that the care exercised must have been of a custodial character only. The wretchedness and misery of the surroundings of the insane in the early hospitals and lack of proper care and medical treatment from which they suffered are vividly set forth in a report made by a special committee of the Legislative Council of Lower Canada, published in February, 1824,[4] which gives various statis-

[1] "The Insane in Canada," American Journal of Insanity, Vol. LXII, p. 2.

[2] This was the first hospital to be instituted in North America.

[3] From letter of Dr. T. J. W. Burgess, Montreal, Quebec, May 19, 1913.

[4] Reported by the Hon. John Richardson, February, 1824. Quebec, R. E. Desbarats, law printer.

tics and other details regarding the care of the insane, of foundlings and of sick and infirm poor in the *Hopital Général* at Quebec, the *Hopital Général* at Montreal, and in the Ursulines at Three Rivers, for the period from 1808 to 1824.

During early times lunatics, if harmless, were allowed to wander about at will, or were cared for at home; if dangerous they were incarcerated in jails like ordinary criminals. Towards the close of the eighteenth century an act was passed authorizing an appropriation for the maintenance of insane persons in the Province of Lower Canada, at the rate of one shilling and eight pence a day. Under this act the insane were entrusted to the care of the religious communities already mentioned, selected in the districts of Quebec, Montreal and Three Rivers.[1] The report made by the special committee in 1824 contains an appendix giving copies (in both English and French) of the questions and answers received from heads of these three hospitals, as well as from their attending physicians and the sheriffs of the three districts, regarding the confinement of the insane in jails and houses of correction; also the report made by Dr. Hackett, of the Quebec General Hospital, in 1816, to Sir John Sherbrooke on the subject of the insane.

The above committee was instructed to inquire into the purpose for which "public monies" had been expended, and "also to enquire and report whether one lunatic asylum for the whole province, adapted to the improved modern system of treatment of the insane, be not an establishment called for by every principle of humanity; and if so, what the erection would probably cost."

This report shows that from 1800 to the end of 1823 the sum of £17,500, 9s. 11d. was expended in all for the insane at Quebec, Montreal and Three Rivers. The report further says:

The returns received from the three nunneries respectively show that at the *Hopital Général,* Quebec, where insane are attended gratis by Dr. Holmes, senior, there were 18 lodges or cells (12 of which were built at the public expense), in size 8 feet long by 7½ feet broad and 8 in height. There were also 6 cells of a much better description, called by the commissioners "moral cells" (also built at the public expense), about 9 feet square and 9 feet high, for patients in a state of mental disease less violent. Sixteen persons were confined in the *whole* (?) at Quebec in 1824, and

[1] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, 1898.

between 1800 and 1824 the total number was 66 males and 45 females, of whom 35 males and 21 females died in that period, while 22 males and 17 females were discharged as cured or relieved. The committee personally visited the above hospital and found everything that regards the management well conducted, and the moral cells neat and clean; but the others, although they were said to be lately much improved, were such as to preclude the possibility of treatment of persons confined therein upon a regular system with a view to cure.

At the *Hopital Général,* or Grey Sisters' nunnery, Montreal, where the insane are attended gratis by Dr. Selby, senior, there were eight cells, each about 8 feet long, 6 feet 3 inches broad and 7 feet 10 inches high. Between 1800 and 1824, 85 patients were received and confined there, of whom 6 were there in 1824, 29 had died, and 49 had been discharged as cured or relieved.

At the Ursulines, Three Rivers, there were six cells, each about 8 feet long, 6 feet broad and 8 feet high. The whole number of patients confined there was 12, of whom 5 had been discharged, while 4 were then in confinement. Each of the above cells was intended for one inmate, who was solitarily confined therein, day and night, with few exceptions, and only removed to another cell when his own cell was cleaned. The cells each had a small glazed and grated window of about a foot square in the outside wall, and in the passages there were openings above each door which were also grated. Through these windows light was admitted and, when opened, air. In winter there were stoves in the adjoining passages, which heated the cells; and in summer, a window at each end of the passage admitted air; but the ventilation must have been very imperfect.

Such arrangements as these did not permit the enjoyment of external air or exercise, nor of moral or even of medical treatment, upon any system affording a hope of mental cure. The cells were simply places of confinement in which the insane were placed to prevent their doing harm to others and to diminish the risk of harm to themselves which would result from their personal freedom. There was no possibility of beneficial effect upon the unhappy patients. The committee expressed the opinion that they rather resembled places for criminals (the said six moral cells at Quebec excepted), and were more likely to produce or increase insanity than to cure it.

Between 1800 and 1814 there were confined in the cells of the three districts 207 insane persons, of whom 93 were discharged, 88 died and 26 remained in confinement. Any apparent benefit or relief afforded must have proceeded from constitutional or accidental causes, and not from any benefits attendant on moral or medical treatment during their confinement in those miserable abodes.

In the year 1818 the sum of £2500 currency was granted for erecting additional cells and making repairs at the General Hospital of Quebec, and £336 was afterwards granted for other repairs thereto. In 1818 £2000 was devoted to a like purpose at Montreal.

The ladies of the *Hopital Général* there and Dr. Selby, Sr., the commissioner, to their honor declined to receive the £2000, as it would increase what was in itself bad and inadequate to the object.

The committee reported that it was deeply to be regretted that so much public money should have been expended in the several districts upon these miserable expedients, in lieu of an establishment for the insane, when, by the application of that money to the same humane object, upon a proper principle, a lunatic asylum might have been erected, calculated to do honor to the province, instead of being a reproach to its inhabitants. They also stated that:

In the treatment of the insane in other countries a great and happy change has been wrought of late years; coercion and confinement beyond that which may be indispensably necessary in special cases are proscribed; and mildness of treatment, with enjoyment of air, exercise and amusement out of doors, and comforts within, are substituted where practicable, with the happiest effects. To each asylum a considerable portion of ground is attached for those purposes.

The security consistent with the safety of the insane, their connections and general society can hardly ever, in the heart-rending circumstances attendant on mental derangement, be enjoyed in the dwellings of private families; removal from home, therefore, is generally necessary, in most cases desirable, and tends to destroy or weaken the morbid associations.

The committee also found that the want of a public lunatic asylum impeded the administration of justice by obliging the judges, from necessity, to condemn insane criminals, when convicted, to be confined in the common jails and houses of correction, where their situation was deplorable to themselves and a nuisance to the other persons confined therein—besides interfering with the classification of prisoners. "The turnkeys and keepers in those establishments cannot be expected to possess qualifications requisite for the management of insane persons. In 1824 three insane criminals were in the jail at Quebec; seven in the jails and two in the temporary house of correction at Montreal. There were none at Three Rivers."

In the opinion of the committee the benefits of a lunatic asylum should be extended to the whole province, with a view to general utility and economy, and not to districts. Indeed it might embrace both the provinces of Canada, in contribution to the expense and enjoyment of its advantages.

This being a general object of great importance, a portion of the public revenue could, with great propriety, in their opinion, be applied to the purchase of the ground, the erection of the building, and annual support of the establishment. They recommended that the site should be healthy and in the neighborhood of a populous town; at such a distance as to possess the advantage of retirement, yet admit of the benefit of medical aid, and enable the institution to be regularly visited, which is of much moment.

After describing in detail the lunatic asylum at Glasgow, Scotland, and recommending this as a model, the report continues:

The committee, therefore, cannot but confidently hope in the means being supplied, by constitutional authority, for the establishment of an institution recommended by the best feelings of our nature, as no human can be considered exempt from insanity, that awful visitation of the Almighty.

And in their final resolutions the committee further said:

Resolved, as the opinion of this committee, That the cells appropriated to the insane in this province do not admit of properly applying either moral or medical treatment, with a hope to a mental cure of the unhappy persons confined therein, and are more likely to produce or increase insanity than to remove it.

Resolved, as the opinion of this committee, That humanity loudly calls for the establishment of a lunatic asylum for the whole province, or for both provinces, for the reception and treatment for cure of the insane, upon the improved modern system, as also for the ultimate care and support of such as are incurable, and that such asylum should be erected in the neighborhood of one of the populous cities of this province, so as to have the benefit of medical aid, and adequate frequent visitation.

Resolved, as the opinion of this committee, That the monies which have been expended for the confinement and support of the insane of this province since the year 1800 would have sufficed for the erection of a lunatic asylum that would have done honor to the humanity and philanthropy of the country.

Dr. Hackett, in his letter to Sir John Sherbrooke in 1816, portrays in detail the inadequacy of the treatment of the insane provided in the Quebec General Hospital, and concludes as follows:

The impracticability at present of adopting even any part of the modern plan of treating the insane will be obvious to Your Excellency; therefore,

under existing circumstances, I conceive medical treatment perfectly useless, and any attempt at moral, not only absurd, but in truth bordering on the ridiculous.[1]

The conditions prevailing in the Province of Quebec were typical of the conditions existing in the other provinces of Old Canada. In New Brunswick, while the population of the province was yet sparse and the insane but few in number, each county cared for its lunatics as best it could, the law authorizing "any two justices of the peace to issue a warrant for the apprehension of a lunatic or mad person and cause him to be kept safely locked in some secure place directed and appointed by them, and, if they deemed it necessary, to be chained." Under this law the indigent insane were confined in jails and poorhouses, while those able to bear the expense were sent to asylums abroad.[2] This condition was in part remedied when, in 1835, a small wooden building in the city of St. John, originally erected as a cholera hospital in 1832, was converted into a temporary asylum for lunatics. This institution was the first of its kind in Canada.[3]

No provision for the care of the insane existed in Ontario previous to the establishment of the Toronto Asylum in 1841. Those who could not be cared for at home were maintained in the

[1] See the following references:

Clark, Sir James: "A Memoir of John Conolly, Comprising a Sketch of the Treatment of the Insane in Europe and America," pp. 268-277. London, 1869.

Monseignier de Saint: Vallier et L' Hopital Général de Quebec. Quebec, C. Darveau, 1883.

Tuke, Daniel Hack: "The Insane in the United States and Canada," pp. 189-242. London, H. K. Lewis, 1885.

"A Report of the Special Committee of the Legislative Council of the Province of Lower Canada, appointed to Enquire into and Report upon the Establishments in this Province for the Reception and Cure of the Insane, for the Reception and Support of Foundlings, and for the Relief and Cure of Sick and Infirm Poor, with the Expenses thereof Defrayed out of the Provincial Revenue, etc." Reported by the Hon. John Richardson, February, 1824. Quebec, R. E. Desbarats, law printer.

DeWolf, James R., M. D.: "Hospitals for the Insane in British North America." Journal of Mental Science, London, January, 1869, pp. 466-470.

[2] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, 1898.

[3] *Ibid.*

county jails. In 1830 an act was passed by the House of Assembly of the then Province of Upper Canada, authorizing the General Quarter Sessions to make provision for the relief of destitute lunatics in the home district. This act did not contemplate the erection of an asylum, but proposed merely to legalize payments for the maintenance of lunatics in county jails. In 1833 it was extended to all the districts of the province.[1]

No reference is found in regard to lunatic persons or paupers, in Prince Edward Island, prior to 1820. In that year, however, small amounts were granted out of the public funds to some especially needy cases. In 1828 the sum of £118 19s. and 4d. had been reported as spent in support of lunatics and other indigent persons during the previous year.[2] There is no record as to how this money was spent, or in what the care given to these unfortunates consisted. The asylum at Charlottetown was opened on May 1, 1847.

In Nova Scotia, previous to 1858, pauper lunatics were sent to the "Lunatic Ward" of the Provincial and City Poor's Asylum in Halifax, or cared for at home. Patients whose friends could afford to pay for them found accommodations in the United States, or in the adjoining Province of New Brunswick.[3] The asylum at Halifax was opened on December 26, 1858.

In the early days of British Columbia, when it was yet a Crown colony, lunatics were placed in the colonial jail in Victoria.[4]

During the rush to the Cariboo gold fields many persons broke down under the mental strain and hardships endured. In 1858 and 1859 the authorities began to send these insane persons back to California, whence a number of them had come. This continued until the authorities gave the government to understand that the practice could not continue. The insane were accordingly placed in the jail at Victoria and the more manageable ones were sent to the Royal Hospital. These places served for patients of the male sex, but when female patients began to appear further

[1] *Ibid.*, p. 14.

[2] See "The Care of the Insane in Prince Edward Island" in a subsequent volume.

[3] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, 1898.

[4] *Ibid.*

provision was necessary, and accordingly a woman's hospital was opened in Victoria. In 1872 the old royal hospital was remodeled and made into an asylum proper.[1]

Previous to 1871 there seems to have been no provision for lunatics in Manitoba. The population was sparse, and among Indians insanity was not at all common. In 1871 the dominion government established the Manitoba Penitentiary at Lower Fort Garry, in one of the old stone warehouses of the Hudson Bay Company. Here from 1871 to 1877 the insane were cared for. Except in the case of females, no separate provision was made for lunatics, they and the convicts being treated alike. In 1883 the Legislature passed an act authorizing the building of an asylum, which was located at Selkirk, and opened in May, 1886.[2]

By special arrangement with the Dominion government all cases of insanity occurring in the Northwest Territories and Keewatin were cared for in the provincial asylums of Manitoba, at a rate of $1 per day each.[3] This included the insane in what are now the provinces of Alberta and Saskatchewan and the Yukon Territory.

The subsequent establishment of asylums in these territories will be treated of in the following chapter.

[1] See "History of the Care of the Insane in British Columbia" in a subsequent volume.

[2] Burgess, Dr. T. J. W.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, 1898.

[3] *Ibid.*

III.

ESTABLISHMENT OF PROVINCIAL INSTITUTIONS.

The first provincial institution for the care of the insane in Canada was established at St. Johns, New Brunswick, in 1835. It consisted of a small wooden building originally erected as a cholera hospital, which had been converted into an asylum for lunatics.[1] In 1848 this temporary refuge was abandoned and the inmates, 90 in number, transferred to the present institution, the erection of which had been begun two years previously.[2]

Ontario, then called Upper Canada, was the next of the provinces to make a movement towards providing for its insane when an abandoned jail at York, now Toronto, was fitted up as a temporary asylum in 1841.[3] This establishment was continued in use up to 1850, in which year the patients were transferred to the present Toronto Asylum.[4] A new hospital is now (1915) under construction at Whitby, which, when completed, will replace the Toronto Asylum.

Kingston Asylum, generally known as Rockwood Hospital, was the second asylum in the Province of Ontario, and was opened in 1856. It was designed as a criminal lunatic asylum, and remained in charge of the federal government, as an adjunct to the penitentiary, until 1877. In that year it was purchased by the local Legislature and became one of the provincial asylums.[5]

The next in order of erection are London Asylum, established at Fort Malden, in 1859, as a branch of the Toronto Asylum, made an independent institution in 1861 and moved to its present location in 1870; Orillia, established at Orillia as a branch of the Toronto Asylum in 1861, in a large building originally designed as a hotel, and abandoned in 1870 on the transfer of the patients to a new asylum then opened at London; Hamilton, originally built as an inebriate asylum in 1879, but utilized for the care of the insane instead; Mimico Asylum, opened as a branch of the Toronto Asylum in 1890 and made independent in 1894; Brockville Asylum, opened in 1894; Cobourg Asylum, opened in 1902; and

[1] Burgess, Dr. T. J. W.: American Journal of Insanity, Vol. LXII, p. 3.
[2] *Ibid.* [3] *Ibid.* [4] *Ibid.*, p. 5. [5] *Ibid.*, p. 6.

Penetanguishene, formerly a reformatory, transformed into an asylum, which was opened in 1904. In 1876 there was established at Orillia, in quarters formerly used as an insane asylum, an asylum for idiots, which was rebuilt in 1887.[1] In 1912 there was begun at Whitby a new institution, designed to take the place of the Hospital for the Insane in the City of Toronto, the site of which had been sold by the provincial government.

Quebec is the only one of the provinces of the dominion in which there is no provincial institution for the care of the insane.[2] The Quebec Lunatic Asylum, formerly known as Beauport Asylum, was established in 1845 by three physicians of the City of Quebec, Drs. James Douglas, Joseph Morrin and Charles J. Fremont, who acquired by lease a property in the parish of Beauport, once a large stone manor-house, which they converted by additions into an asylum. The agreement of the proprietors with the government was that they should be paid at the rate of $143 annually for each public patient. Being subsidized by the province the establishment was placed under the supervision of a board of commissioners.[3]

In 1848 the establishment was removed to a new location about a mile distant from the original site and a new asylum erected. After successive changes of ownership the asylum passed by purchase into the hands of the Sisters of Charity of Quebec in April, 1893.

St. Johns Asylum, the only attempt at state care ever made in the Province of Quebec, was established in an old building, formerly used as a court-house, in St. Johns in August, 1861. On July 20, 1875, this institution was closed, the inmates being removed to Longue Pointe Hospital, under the care of the Sisters of Charity.[4]

L'Hospice St. Jean de Dieu, or, as it is usually known, Longue Pointe Asylum, was established in 1852. It is a proprietary institution established by and still the property of the Sisters of

[1] *Ibid.*, p. 6.

[2] Burgess, Dr. T. J. W.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, p. 47.

[3] *Ibid.*, p. 50.

[4] See "History of St. Johns Asylum" in a subsequent volume.

Charity. The Protestant Hospital, generally known as Verdun Hospital, is a corporate hospital, established by a number of Protestant citizens of Montreal, and opened in 1890. There are besides, two institutions which receive idiots as well as aged and infirm paupers. These are L'Hospice St. Julien, located at St. Ferdinand d'Halifax, and Baie St. Paul Asylum, at Baie St. Paul. The former was opened for the reception of idiots in 1873 and the latter in 1890. Both belong to the Sisters of Charity.[1]

Prince Edward Island has a provincial hospital for the insane, erected in 1847, but idiots and imbeciles are cared for in the provincial poorhouse.[2]

Nova Scotia established a hospital for its insane in 1858. It has, however, since 1886, sanctioned the erection of county asylums, in many cases county asylums combined with county poorhouses. In 1904 there were 18 of these structures, which housed sane adults, children, insane patients, imbeciles, and epileptics.[3]

In 1871 Manitoba established its first asylum at Lower Fort Garry, in conjunction with the Manitoba penitentiary. In 1877 the lunatics were removed to Stony Mountain, where the present penitentiary had been erected. In 1884 they were brought back to their old quarters at Lower Fort Garry. In 1886 the present asylum, located at Selkirk, was established. The second asylum for the insane of the province is located at Brandon, and was opened in 1891.

In 1890 a home for incurables was opened at Portage la Prairie, a town some 50 miles west of Winnepeg. Although not intended for mental cases, owing to overcrowding at Selkirk there were transferred to it on its opening some 17 cases. This action, combined with the fact that imbeciles and idiots are by law non-admissible to the insane hospitals, has led to the adoption of a portion of this institution as a refuge for harmless patients of these classes.

British Columbia established a temporary asylum for the care of the insane outside the City of Victoria in 1872. This was removed to New Westminster and made permanent in 1878. This institution became overcrowded in 1906 and 1908, and a "colony farm" was purchased in the valley of the Frazer River, at a point

[1] Burgess, Dr. T. J. W.: American Journal of Insanity, Vol. LXII, p. 7.
[2] *Ibid.*, p. 14. [3] *Ibid.*, p. 11.

where it is joined by the Coquitlan River. The provincial government decided to make this a separate institution, however, and it was opened as such on April 1, 1913.

Prior to its organization as a separate province September 1, 1905, Alberta formed part of the Northwest Territory. In 1907 an act was passed by the Legislature which provided for the erection of an asylum, or the procuring of a building for temporary use until a proper asylum could be established. The result was the establishment of the insane asylum at Ponoka, which was opened for the admission of patients on July 4, 1911.

Saskatchewan, like Alberta, became a separate province on September 1, 1905. In 1906 the Legislature of the province passed an act which provided that anyone deemed mentally unsound could be taken to a justice of the peace, who might, did the evidence show sufficient reason, commit such person to the nearest jail, there to stay until the Attorney General should order his removal to an asylum in Saskatchewan or another province. The maintenance of all pauper lunatics was made a provincial burden by the same law.

Nothing was done, however, towards the erection of an asylum until 1911, when a site was finally selected near the town of Battleford, on the Canadian Northern Railway. In August of that year work was begun on the new hospital, and it was completed and occupied on February 4, 1914. It is known as "The Saskatchewan Provincial Hospital."

There are no asylums for the insane in the Yukon and Northwest territories. The early care of lunatics and their conveyance to an institution in one of the neighboring provinces usually falls to the lot of the members of the Royal Northwest Mounted Police. Those from Yukon are sent to the asylum at New Westminster, British Columbia; those from the Northwest Territory to the asylums of Alberta and Saskatchewan. The daily maintenance charge paid by the Dominion government for their keep is $1 per patient.

IV.

SYSTEM OF CARE IN THE PROVINCES OF CANADA, AND GOVERNMENT AND INSPECTION OF PROVINCIAL INSTITUTIONS.

Excepting as regards the Province of Quebec, an account of which is given in a separate chapter,[1] the methods of care of the insane in the various provinces which go to make up the Dominion of Canada are, in a large measure, similar in character. These various methods are gone into in detail in the chapters pertaining to the individual histories of Canadian institutions which are published in a subsequent volume. In the following pages are given brief outlines only of the methods of care, and of the government and inspection of provincial institutions.

In New Brunswick, St. John Asylum, which was opened in 1835, continued under charge of a layman, then the overseer of the poor, with a visiting medical officer, until 1843. In that year it was first styled the Provincial Lunatic Asylum and was placed in the care of a board of commissioners, one of whom acted as medical superintendent. This board continued in charge until the opening of the new asylum in 1848. This new asylum was placed under the management of a board of commissioners, consisting of not less than five nor more than nine members, appointed by the Governor in Council, and who served without compensation. Provision was made for a monthly visitation by one or more members, half-yearly visitations by the majority of them, and a yearly visitation by the entire board, which had to report to the Governor in Council.

The asylum was, from its opening, under the charge of a medical superintendent.

In 1859 the control of the asylum was vested in the Provincial Board of Works. In 1861 the internal affairs of the institution were transferred to a new commission, consisting of the heads of governmental departments. The system then adopted still

[1] "The Contract System of the Care of the Insane in the Province of Quebec."

remains in vogue, the commissioners retiring with any change of government.[1]

New Brunswick, since the time of the establishment of its first asylum, has declared against the incarceration of lunatics, even temporarily, in prisons or poorhouses. The province has recognized that the insane are wards of the state and has always endeavored to provide for all classes of sufferers from mental disease.[2]

A custom peculiar to the New Brunswick institution is the collection of an admission fee of $20, either from relatives or municipalities, for every patient received into the hospital. This custom has been in force as far back as can be traced, and has become so well established that everyone expects to pay it, and there is never any objection to its payment. Beyond this payment none was made by the municipal authorities, the whole outlay being met by the government. To remedy this a law was passed in 1894 to charge the counties $1.25 per week each for all harmless patients. This law met with violent opposition and became practically a dead letter. In consequence a new act was passed in 1913, which requires the counties to pay $1 per week per capita for all their insane, whether harmless or not, if relatives do not pay this amount or more.[3]

The first asylum established for the insane of Ontario was opened in January, 1841. It was located in the old York jail, which had been abandoned as such, and which had been converted into a temporary asylum, under the management of a commission of four members, appointed by the Lieutenant Governor; there was also a medical superintendent in direct charge of the patients.

In July, 1843, the original commissioners were, in accordance with the provisions of the act of 1839, increased in number to 12.

In 1846 an additional temporary asylum was established as a branch of the original asylum, and under the same management in the east wing of the old Parliament buildings in Toronto.

[1] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, pp. 5-10.

[2] *Ibid.*, p. 14.

[3] See "History of the Care of the Insane in New Brunswick" in a subsequent volume.

These buildings were abandoned in January, 1850, when the permanent asylum, known as "The Provincial Lunatic Asylum," was opened for the reception of the insane of the province.

Up to 1850, when the temporary asylums were abandoned, their condition was far from creditable, a fact in great measure due to the changes in management, which occurred with startling rapidity.[1] Mr. J. H. Tuke, who visited the asylum in 1845, made the following entry in his diary:[2]

> Toronto, September 30, 1845.—Visited the lunatic asylum. It is one of the most painful and distressing places I ever visited. The house has a terribly dark aspect within and without, and was intended for a prison. There were, perhaps, 70 patients, upon whose faces misery, starvation and suffering were indelibly impressed. The doctor pursues the exploded system of constantly cupping, bleeding, blistering and purging his patients; giving them also the smallest quantity of food, and that of the poorest quality. No meat is allowed—I left the place sickened with disgust, and could hardly sleep at night, as the images of the suffering patients kept floating before my mind's eye in all the horrors of the revolting scenes I had witnessed.

The same may be said of the new institution up to the time Dr. Workman became superintendent in 1853.

According to Dr. Burgess:[3]

> Much that is best in the present system of caring for the insane in Canada can be traced to the wisdom of this accomplished gentleman, fittingly styled by Dr. D. Hack Tuke "the Nestor of Canadian alienists." Under his régime mere custodial care, with more or less neglect and cruelty, gave place to a system of kindness and scientific treatment.

On June 20, 1853, the old board of 12 directors was replaced by a visiting committee. The act authorizing this change also vested the property in the Crown; placed the appointment of the medical superintendent, as well as that of the bursar, in the hands of the government, and gave to the superintendent power to hire and dismiss all officers and servants other than the bursar.

This new system of control remained in force up to December, 1859, when, under provision of the Consolidated Statutes of

[1] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, p. 22.

[2] Tuke, D. H., M. D.: "The Insane in the United States and Canada." London, 1885, p. 214-215.

[3] "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, p. 29.

Canada, the visiting committee was superseded by the appointment of a board of five inspectors by the legislative assembly.[1]

After confederation of the provinces on July 1, 1867, the asylums, with the jails and other public institutions, came under the control of the local Legislatures; in 1868 Ontario adopted the present system of direct governmental supervision, through an inspector appointed for that purpose.[2]

The Legislative Assembly of the Province of Ontario in 1871 enacted "An Act Respecting Lunatic Asylums and the Custody of Insane Persons."[3]

Under the provisions of this act the public asylums are established and acquired under a grant from the Legislature of the province, and are vested in the Crown. The Lieutenant Governor has the appointment of the medical superintendent. Among the duties of this last-named officer are those of reporting the condition of the asylum to the Inspector of Prisons and Public Charities at each visit, and also of reporting annually to the inspector upon the affairs of the institution. The financial affairs of asylums are conducted by the bursar, who is appointed by the Lieutenant Governor.

The asylums of Ontario are state institutions in the fullest sense of the word. In the majority of cases the patients are maintained entirely at government expense; in other cases, where they are able to do so without hardship, the friends are charged a rate that covers the bare cost of keep.[4]

A striking feature of the early history of the asylums in the Province of Ontario is the extent to which the acquisition of "branch asylums" developed. These in most cases were designed to relieve overcrowding without the expense of adding additional buildings to the original asylum. In general they occupied abandoned buildings, unsuited in every way for asylum purposes, and were in some cases put under the charge of an assistant physician. Ultimately they were abandoned or became in themselves the nuclei of independent institutions.

[1] *Ibid.*, p. 31. [2] *Ibid.*, p 33.

[3] Tuke, D. Hack: "The Insane in the United States and Canada." London, 1885, p. 209.

[4] Burgess, T. J. W., M. D.: American Journal of Insanity, Vol. LXII, p. 14.

Thus the Toronto Asylum when it opened in 1850 was the consolidation of three temporary asylums, maintained in the old jail, Parliament buildings, and a Bathhurst Street house respectively. To relieve overcrowding, in July, 1856, a building which had been erected as the commencement of the University of King's College was converted into a supplemental asylum. In 1859 the old military barracks at Fort Malden were converted into another branch asylum. This was made an independent asylum in 1861. Yet another branch asylum was established at Orillia in 1859,[1] which was continued in operation up to 1870, when it was abandoned on the transfer of the patients to the new asylum, then opened at London.

A like situation occurred at Rockwood Asylum in 1885, when an old stone building in the City of Kingston, originally erected as a Roman Catholic seminary, was rented, renovated and occupied by patients of the chronic class. It remained in use up to February, 1891, when the opening of the new institution at Mimico allowed it to be dispensed with.

At first the administration of Mimico Asylum was directed from the Toronto Asylum, of which it was a branch, known as the Mimico Branch Asylum. It was so conducted from its opening, January, 1890, up to its transformation into an independent asylum in November, 1894.

In Prince Edward Island the administration of the affairs of the Asylum for Insane Persons, opened at Charlottetown in 1847, was vested in a board of eight trustees. The asylum was under the direct charge of a master and matron; there was in addition a medical officer, who visited the institution once or twice a week.

This arrangement continued until 1874, when a report of the grand jury of that year, containing as it did a scathing denunciation of the management of the asylum, paved the way for certain reforms. The report of the grand jury[2] disclosed a condition of affairs so repugnant that it is hard to believe that an institution so conducted could exist in a civilized community. In a cell below the ground, about six by seven feet, they found a young woman

[1] This asylum was again opened in 1876 for the accommodation of 150 idiots, and continues to care for this class of patients up to the present.

[2] See "History of the Care of the Insane in Prince Edward Island" in a subsequent volume.

entirely naked, beneath some broken, dirty straw. The stench was unbearable. In another cell, about the same size, another young woman was closely confined. To quote the report:

> The whole asylum is in one state of filth; men's rooms and women's exhibit an utter absence of the slightest attempt at cleanliness, while the stench was such that some of the jury were ill for hours after inhaling it.

The immediate result of the report was the removal of the officers and a change of conditions as far as circumstances would permit. The movement thus started led to the passage in 1877 of a new lunacy act [1] providing for the erection of the Prince Edward Island Hospital for the Insane, and the creation of the office of medical superintendent. At the same time the Board of Trustees was reduced in number to five members, who were to meet quarterly at the hospital, one of them to visit the hospital once a week.

The new hospital was opened on December 10, 1879. In 1889 the medical superintendent was again made a visiting officer, instead of a resident one, and this arrangement has continued in force up to the present.

In 1909 The Provincial Infirmary, known as the Poorhouse, was erected on the asylum grounds and placed under the same medical supervision. To it are transferred from the hospital proper, idiots, imbeciles and dements, provision being made for their re-transfer to the hospital by the superintendent if deemed necessary.

This combination of a poorhouse and asylum is a distinctly backward step in the care of the insane in Prince Edward Island.[2]

Previous to 1858 the pauper lunatics of Nova Scotia were sent to the lunatic ward of the Provincial and City Poor's Asylum in Halifax, or cared for at home in what way can be imagined.[3] In that year, however, the Provincial Hospital for the Insane was opened for the reception of patients, its object being defined as "the most humane and enlightened curative treatment of the insane of this province." This institution, now the Halifax City

[1] 38 Victoria, Cap. 4.

[2] Burgess, T. J. W., M. D.: "Canadian Institutions for the Insane." Proceedings and Transactions Royal Society of Canada, Second Series, Vol. IV, p. 100.

[3] *Ibid.*, p. 100.

Asylum and Poorhouse, was supported jointly by the province and city. It received paupers from all parts of the province, and had two wards for lunatics.[1]

The management of the hospital was at first vested in a body of commissioners, nine in number, appointed by the Governor in Council. There was in addition a medical superintendent in direct charge of the patients.

Insane transient paupers were authorized to be received at provincial expense, but only after the commissioners had been satisfied by affidavit that such persons were not properly chargeable to any township or county of the province.[2]

In 1860 the control of the hospital was vested in the Board of Public Works. In 1867 a board of three commissioners was appointed to replace the Board of Works in the general supervision of the hospital, part of their duty being to visit it weekly. In 1878 this board gave place to a Board of Public Charities, consisting of five members. Of the new board the Commissioner of Works and Mines was chairman and the Mayor of Halifax an *ex-officio* member.[3] In 1886 the government abolished the Board of Public Charities and made the Commissioner of Public Works and Mines the sole authority. This arrangement is still in vogue, but has been supplemented by the appointment of an Inspector of Public Charities, making the system practically identical with that of Ontario.[4]

The maintenance of the hospital is undertaken by the government, the lands and buildings being provided by the province. The municipalities are charged at the rate of $3.50 per capita per week for the patients they send in.

The institution is the only one of its kind in the province, but since 1886 a few counties have erected county asylums, and a number combined county asylums and poorhouses. To these can be transferred the harmless insane from the provincial hospital, and to them can be sent direct idiots, non-violent epileptics and cases of chronic insanity refused admission there upon statutory grounds.[5]

Up to 1873 no act had been passed for the founding or regulation of asylums in British Columbia, but in that year an act known

[1] *Ibid.*, p. 101. [2] *Ibid.*, p. 103. [3] *Ibid.*, p. 104. [4] *Ibid.*, p. 105.

[5] See "The Care of the Insane in Nova Scotia" in a subsequent volume.

as the Insane Asylums Act came into force.[1] It fixed the title of the new establishment as "Asylum for the Insane, British Columbia," and placed it in the charge of the Provincial Secretary, under whose department it has remained ever since. The direct management of the asylum was in the hands of a non-resident "medical superintendent" and a "superintendent of the asylum," the latter a resident layman, whose duty it was to look after the internal economy and discipline.[2] The act of 1873 was amended in 1893,[3] and, together with the amendment, repealed in 1897, a new act, the Hospital for Insane Act,[4] replacing it.

In 1885 the hospital was placed in charge of a medical superintendent.

The system of management of the Public Hospital for the Insane, New Westminster, as well as the British Columbia Mental Hospital at Coquitlam, are under the control of the Provincial Secretary.

The system of management in the Manitoba asylums is similar to that used in Ontario, they being under the supervision of an inspector, who is directly responsible to the government.[5] In the case of destitute patients the province pays all expenses. All treaty Indians are paid for by the dominion government.

By an act of the Legislature of the Province of Alberta, passed in 1907, and entitled the Insanity Act, the insane and their affairs were placed in charge of the department of the Attorney General.[6]

An act of the Legislature of Saskatchewan of 1906, known as the Attorney General's Act,[7] placed in the Attorney General's department the superintendence of prisons, asylums, houses of correction and other places of confinement within the province, also the inspection of all certificates bearing upon the admission and discharge of lunatics to and from asylums. To the department of public works by this act was deputed the construction, charge and direction of all such government buildings. The maintenance of all

[1] See "The Care of the Insane in British Columbia" in a subsequent volume.

[2] *Ibid.*

[3] 56 Victoria, Chapter 18.

[4] 60 Victoria, Chapter 17.

[5] See "The Care of the Insane in Manitoba" in a subsequent volume.

[6] Statutes of Alberta, 7th ed., VII, Cap. 7.

[7] Revised Statutes of Saskatchewan, 1906, Cap. 22, Sec. 1.

pauper lunatics was made a provincial burden by the same enactment.

The care of the insane in the Yukon and Northwest Territories and their conveyance to an institution in one of the neighboring provinces falls to the lot of the Royal Northwest Mounted Police, there being no asylum in these districts. The daily maintenance charge paid by the Dominion Government for the care of the insane of these territories is $1 per day per capita.[1]

[1] See "The Care of the Insane in the Yukon and Northwest Territories" in a subsequent volume.

V.

THE CONTRACT SYSTEM IN THE PROVINCE OF QUEBEC.

At the present time the insane of the Province of Quebec are cared for in five hospitals, four of which, namely, The Quebec Lunatic Asylum, known as Beauport Asylum; L'Hospice St. Jean de Dieu, known as Longue Pointe Asylum; L'Hospice St. Julian, and Baie St. Paul Asylum, are proprietary institutions, owned by and under the charge of the Sisters of Charity. The fifth hospital is the Protestant Hospital for the Insane, commonly called Verdun Hospital, which is a corporate charitable institution, erected in large measure by a number of Protestant citizens of Montreal. The leading clause in its charter of constitution stipulates that all monies received by the corporation, from whatever source, shall be expended upon the institution and its inmates.

All public patients in the Province of Quebec are cared for in these five institutions, under contract with the government for the sum of from $100 to $142 per year. In addition there have been at times grants made by the government to different institutions. In the latter case the asylums receiving such grants are under the control of the government; all other asylums are under its supervision only. The Lieutenant Governor appoints a medical superintendent for each asylum under a contract with the government; he also appoints in addition an assistant medical superintendent and one or two house physicians for the three asylums, known as St. Jean de Dieu, Verdun and Beauport. The salaries of these officials are paid by the government.

The duties of the officers thus appointed are defined by law. Briefly stated they are as follows:

The medical superintendent supervises the admission and discharge of patients; he controls the medical service, the classification of patients and their treatment; he formulates all rules and regulations for the medical, moral and physical treatment of patients; he may require proprietors to dismiss nurses or guardians for incompetence or insubordination; he is required to make an annual report to the Provincial Secretary respecting the patients under his care.

The assistant medical superintendent exercises the powers of the superintendent in the event of his absence or inability to serve. The house physicians are required to devote their whole time to the service of their patients and to reside near the asylum.

The above regulations, while not overcoming the errors of the "farming-out system" of the care of the insane, have served in a measure to correct some of the most glaring evils consequent to such arrangement. How many and great these evils were, a brief survey of the history of the efforts made to correct the system will serve to indicate.

Of Beauport Asylum, in 1869, Dr. James R. DeWolf states:[1]

> Next to the Toronto Asylum in point of seniority is that at Beauport, near Quebec, a private institution, in which there are 600 patients. A large majority of these are supported by the Province of Quebec, the proprietors receiving a liberal allowance for their maintenance. Although the present buildings are comparatively new, the inmates are crowded, while the ventilation is greatly defective. Many of the single dormitories are prison-like in the extreme, having no windows, but opening into a corridor by a door with an open space above. This most objectionable arrangement is all the less excusable, since the proprietors are themselves medical men.[2]

A still darker picture is that given 15 years later by Dr. D. Hack Tuke.[3] Speaking of the same institution he states:

> But it is needless to describe in more detail an institution which, however willingly I may praise where praise is due, is so radically defective in structure and so fundamentally different from any well-conducted institution of the present day, in the matter of moral, to say nothing of medical treatment, that no tinkering of the present system will ever meet the requirements of humanity and science; and again, the proprietors receive $11 per head per month for maintenance and clothing. This system involves the probability of patients being sacrificed to the interests of the proprietors.

Speaking of Longue Pointe Asylum he writes:

> It is impossible to convey an adequate idea of the condition of the patients confined in the gallery in the roof and in the basement of this asylum. They constitute the refractory class—acute and chronic maniacs. They and the accommodation which has hitherto been provided for them must be seen to be fully realized. To anyone accustomed to a well-ordered institution for the insane the spectacle is one of the most painful character. In the

[1] Journal of Mental Science, Vol. XIV, p. 466.

[2] Beauport did not come under the control of the Sisters of Charity until 1893.

[3] "The Insane in the United States and Canada," H. K. Lewis, London, 1885.

course of seven and thirty years I have visited a large number of asylums in Europe, but I have rarely, if ever, seen anything more depressing than the conditon of the patients in those portions of the asylum at Longue Pointe to which I now refer.

And further, after describing conditions in detail:

Into this human menagerie, what ray of hope can ever enter?

And again:

But it is amazing to reflect that although the superiority of the humane mode of treating the insane inaugurated nearly a century ago has been again and again demonstrated, and has been widely adopted throughout the civilized world, a colony of England, so remarkable for its progress and intelligence as Canada, can present such a spectacle as that I have so inadequately described as existing, in the year of grace 1884, in the Montreal Asylum.

At the time of Dr. Tuke's report there were three inspectors of the asylums and prisons of the province, whose duty it was to report to the Provincial Secretary, to whose department the institutions were subject. The inspectors were supposed to visit the different institutions three times each year. The grand jury also was empowered to visit the asylums and make presentment to the court in regard to their condition. There was likewise a visiting physician, appointed and paid by the government. It seems from Dr. Tuke's report [1] that the duties of the inspectors and the grand jury were performed in a purely formal manner, and that the authority of the visiting physician was practically nil. It is true that an act of the Quebec Legislature, passed in June, 1884, extended and enforced the authority of this officer, but it had little or no apparent effect in the conduct of the institution.

Following the visit of Dr. Tuke to the Quebec asylums, a meeting of the Medico-Chirurgical Society of Montreal was held, November 7, 1884, when the following resolutions were unanimously passed: [2]

1. That this society has every reason to believe that the statements contained in the report of Dr. D. Hack Tuke, of London, England, upon our provincial lunatic asylums, are, in every material respect, true and well founded.

2. That these statements show a most lamentable state of things as regards the general, and especially the medical, management of these institutions.

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[1] *Ibid.*, p. 200.

[2] Canada Medical and Surgical Journal, Nov., 1884.

3. That it appears to this society to be the imperative duty of the provincial government to institute a thorough investigation by competent persons into the entire system of management of the insane poor in this province.

4. That the "farming" or "contract" system, either by private individuals or by private corporations, has been everywhere practically abandoned, as being prejudicial to the best interests of the insane and producing the minimum of cures.

5. That in the opinion of this society all establishments for the treatment of the insane should be owned, directed, controlled and supervised by the government itself, without the intervention of any intermediate party.

6. That the degree of restraint known to be employed in our provincial asylums is, according to the views of the best modern authorities, excessive. That the ablest European, American and also Canadian alienists have almost entirely given up any method of mechanical restraint. That these facts call urgently, in the name of humanity, for reform in this direction in our provincial asylums.

The resolutions closed with a statement supporting Dr. Tuke's report that the hands of the visiting physician, Dr. Henry Howard, were tied and that he could not be held responsible for the conditions which existed.

While the report as given above indicates that the medical practitioners of the Province of Quebec were eager and willing that the abuses of the "contract system" be remedied, and that the province should assume the obligation of the care of its insane, nothing was done to remedy existing conditions.

One outcome of the agitation, however, was the establishment of the Protestant Hospital for the Insane, an incorporated charitable institution, which, while paid by the government for the maintenance of public Protestant patients, is safeguarded by the leading clause of its constitution, as already mentioned.[1]

Ten years later a further effort was made on behalf of the insane of the province which resulted in the passage of an act[2] which gave to the government greater powers of supervision and control in regard to the lunatic asylums. These powers are those in force at the present and have already been set forth in the preceding pages of this article.

[1] Burgess, Dr. T. J. W.: American Journal of Insanity, Vol. LXII, p. 10.
[2] R. S. Q. 3183; 57 V. c. 33, SI et seq.

A statement of the care of the insane in Quebec would not be complete without mention of St. Johns Asylum,[1] the only government institution for the care of the insane ever established in the province. This asylum was opened in 1861 and closed in 1875. Its history adds nothing to the credit of the province, the buildings being wretchedly insufficient in every particular for the needs of the insane. The cost of maintenance was excessive, being annually considerably over $200 per capita. It is only fair to state in this connection that the sum paid the Sisters of Charity for the support of the public patients at Longue Pointe was, as late as 1875, but $100 per annum, an utterly inadequate amount for proper care and treatment.

Before Quebec can be counted in the foremost line, where it ought to be, the province must own as well as supervise its institutions for the dependent insane.[2]

[1] See "History of St. Johns Asylum" in a subsequent volume.

[2] Burgess, Dr. T. J. W.: American Journal of Insanity, Vol. LXII, p. 10.

VI.

IMMIGRATION AND THE CARE OF THE INSANE IN CANADA.

The 20th century practically marks the beginning of real immigration to Canada. A reference to the census of population during a period of 40 years, prior to 1900, shows that Canada scarcely maintained an increase throughout the census periods equivalent to a natural increase. This was due in part to the enormous immigration to the American prairies and to the delay in opening to immigration the colder prairies of the Canadian Northwest. There had been an Immigration Act in force, practically since the confederation in 1867, but its provisions with regard to the examination and rejection of immigrants, if existing at all, were imperfect. Two clauses were added to this act in 1902, making it possible to reject at the seaports any immigrants suffering from any "loathsome, contagious or infectious disease, or which may become dangerous to public health." Under the act thus amended, medical immigration inspection began in 1903. In 1904 Dr. Peter H. Bryce was appointed chief medical officer of the service. After observing the operations of the act during 1904 and 1905, with the assistance of the legal department he re-wrote the Immigration Act practically in its present form, and it was made a law in 1906. This act was amended in 1910 and again on April 4, 1911. This last is the act which is in force at the present time (1915).

Section 3 of this act provides that no immigrant, passenger, or other person, unless he is a Canadian citizen or has Canadian domicile, shall be permitted to land in Canada, or in case of having landed in or entered Canada shall be permitted to remain therein who belongs to certain prohibited classes, which this section of the act enumerates. Among the prohibited classes are: (a) Idiots, imbeciles, feeble-minded persons, epileptics, insane persons and persons who have been insane within a period of five years previous. (b) Persons affected with any loathsome disease, or with a disease which is contagious or infectious, or which may become dangerous to the public health, whether such persons intend to settle in Canada or only to pass through Canada in transit to some other country. In the latter case provision is made for medical treatment provided that such disease is curable within

a reasonably short time. (c) Immigrants who are dumb, blind, or otherwise physically defective, unless they are not liable to become a public charge. (d) Persons who have been convicted of any crime involving moral turpitude. (e) Prostitutes, women coming to Canada for immoral purposes and persons living on the avails of prostitution. (f) Persons who procure or attempt to bring into Canada prostitutes or women for other immoral purposes. (g) Professional beggars, or vagrants, or persons likely to become a public charge. In addition there are sub-sections (h) and (i) which refer to charity immigrants and persons not complying with regulations.

Section 5 provides for the appointment by the Governor in Council of a Superintendent of Immigration, Commissioners of Immigration, and such other officers as are deemed necessary for carrying out the provisions of the act.

Section 13 provides for the appointment of a permanent Board of Inquiry for the summary determination of the condition of all cases of immigrants or passengers seeking to enter Canada or detained for any cause under the act.

Section 18 provides that there shall be no appeal from the decision of such Board of Inquiry as to the rejection and deportation of immigrants, or other persons seeking to land in Canada, when such decision is based upon a certificate of the examining medical officer to the effect that such persons are afflicted with any loathsome disease, or with a disease which may become dangerous to the public health, or that they come within any of the following prohibited classes, namely, idiots, imbeciles, feeble-minded persons, epileptics and insane persons.

Section 28 provides that the medical officers appointed under the act shall make a physical and mental examination of all immigrants and passengers seeking to land in Canada.

Section 30 provides that every transportation company shall, for the purpose of the act, be considered as one with any transportation company with which it co-operates or makes or affords connection, whether in Canada or not and whether under the same management or not, and shall be liable for any offense against the act by any company with which it co-operates or makes connection.

Section 33, sub-section 5, provides that an order for deportation shall be made in a form prescribed in the act, and that a copy of the order shall be delivered to the person deported, and to

the master or owner of the ship or to the local agent or other officials of the transportation company by which such person was brought to Canada; and such person shall thereupon be deported by such company subject to any appeal which may have been entered under Section 19 of the act.

Sub-section 8 provides for a penalty for landing or attempting to land any prohibited immigrant of a fine of not more than $500 and not less than $50 for each prohibited immigrant.

Section 34 provides for the medical treatment of any person seeking to enter Canada or who has been rejected or is detained for any purpose under the act, who is suffering from sickness or physical or mental disability, such treatment to be given aboard ship or in an immigrant station or in a suitable hospital as the officers in charge may decide. In the case where the transportation company which brought such person to Canada failed to exercise proper vigilance in so doing, then the cost of such medical attention and maintenance shall be paid by such transportation company. This applies also to the cost of attendant to such person, if such be required during the person's detention, or in case of deportation, then the cost of the accompanier of such person to his port of embarkation from Canada.

Section 40 provides for the deportation of any person who within three years after landing in Canada has been convicted of a criminal offense in Canada, or has become a prostitute, or by common repute has become a person living on the avails of prostitution, or has become a professional beggar or a public charge, or an inmate of a penitentiary, gaol, reformatory, prison, hospital, insane hospital or public charitable institution.[1] In such case it shall be the duty of any officer cognizant thereof, and the duty of the clerk, secretary or other official of any municipality in Canada wherein such persons may be, to forthwith send a written complaint thereof to the Minister or Superintendent of Immigration, giving full particulars.

Section 45 provides for the deportation by vessel or train at the expense of the transportation company of any person coming within the prohibited classes, such deportation being to the place

[1] Any person of the undesirable classes previously enumerated can be deported at any time *within a period of three years* after arrival in the dominion.

in the country whence he was brought or to the place of his citizenship, as the case may be.

Section 47 provides regulations for the proper treatment of persons so deported while awaiting and during deportation.

Section 49 provides for a manifest to be delivered by the master of every vessel arriving at any port of entry in Canada, which shall state the name and age of every passenger on such vessel who is insane, idiotic, epileptic, dumb, blind or infirm, or suffering from any disease or injury under the act.

Sections 76, 77 and 78 provide for prosecutions, procedure and penalties for violations of any provisions of the act.

Clause 40, which places the duty of deporting undesirable classes upon the secretary or clerk of every municipality of Canada, is peculiar to the Canada Immigration Act, and has been of great assistance in the prevention of the congestion of institutions with undesirables.

The following tables, furnished through the kindness of Dr. Peter H. Bryce, will serve to show the increase in immigration subsequent to 1900, as well as the number of immigrants rejected at the seaport or afterwards deported on account of some mental infirmity. The history of the rejections and deportations as seen in the tables illustrates in a large measure the workings of the Immigration Act.

NUMBER OF REJECTIONS AT PORT OF ENTRY.

	Total immigration.	Insanity.	Epilepsy.	Imbeciles, mentally weak, etc.
1900-01	49,149	0	0	0
1901-02	67,379	0	0	0
1902-03	128,364	1	0	1
1903-04	130,331	5	9	0
1904-05	146,266	3	2	4
1905-06	189,064	11	5	11
9 months ending March 1907	124,667	8	3	5
1907-08	262,469	19	4	12
1908-09	146,908	13	0	28
1909-10	208,794	15	4	31
1910-11	311,084	5	8	27
1911-12	354,237	15	5	27
1912-13	402,432	23	0	25
Total	2,521,144	118	40	171

NUMBER OF DEPORTS AFTER ADMISSION.

	Insanity.	Epilepsy.	Imbeciles, mentally weak, etc.
1902-03	1	6	8
1903-04	5	4	9
1904-05	5	2	7
1905-06	12	6	18
9 months ending March 1907	53	6	22
1907-08	110	15	45
1908-09	113	22	36
1909-10	95	8	12
1910-11	121	10	17
1911-12	133	8	10
Total	868	97	193

Despite the provisions of the Immigration Law, the foreign born form a large part of the population of the insane hospitals of the provinces. This has been due in part to the fact that the present deportation law is of recent effect, and in part to the fact that the system of inspection at the ports of arrival is not as complete as it should be.

According to Dr. T. J. W. Burgess:[1]

Unhappily quite a large number of the immigrants brought to us are of a low standard of mentality, some of them even having been inmates of asylums before coming to this country. Such a condition amid new environments and under new conditions of existence is almost sure to lead to mental strain and insanity. The result is that these incompetents, many of them consisting of the scum and dregs of an overcrowded European population, are crowding our provincial hospitals, especially those of Ontario, Manitoba and British Columbia, to which province immigration has been largest, and those contiguous to large seaports, such as Montreal. Most of our institutions have a larger percentage of foreigners than is found among the native population, and while the greater number of the foreign-born inmates are legitimately there, having broken down mentally after they had earned a residence, there is in every asylum a proportion who should never have been brought to our shores. Some of these have come of their own accord, but it is evident from the statements of the patients themselves that in certain cases parochial boards, benevolent societies, municipalities, and even relatives, have sent out persons simply as the cheapest way of getting rid of them.

In Ontario the foreign-born population of the province was, in 1907, about 20 per cent of the total; that year, however, it fur-

[1] American Journal of Insanity, Vol. LXII, p. 19.

nished 38 per cent of the gaol commitments, and in the Central Prison, Toronto, 41 per cent of the prisoners admitted were foreigners.[1]

In Toronto Hospital for Insane, of 422 admissions during 1908, 50 per cent were foreign-born, and of these the great majority were recent arrivals.[2] During the year 1903 there were admitted to Canadian asylums 2213 insane persons. Of this number 487 or 22 per cent were of foreign birth. At Verdun Hospital, of the 2048 patients received up to 1905, 40 per cent were of foreign birth.[3]

The passage of the more rigorous immigration laws as already noted, and a higher degree of care exercised at the ports of entry by those appointed to carry out the provisions of the law, have in the last few years been instrumental in mitigating the evils consequent to the introduction of defective aliens. That this system of care will continue to grow and will eventually prevent Canada from being a "dumping ground" for the mentally unfit of Europe cannot be doubted.

[1] American Journal of Insanity, Vol. LXV, p. 186.

[2] *Ibid.*

[3] Burgess, Dr. T. J. W.: American Journal of Insanity, Vol. LXII, p. 22.

VII.

CENSUS OF THE INSANE IN CANADA.[1]

The Census Department at Ottawa is unable to furnish figures relative to the insane in Canada prior to confederation, which took place in 1867. The earliest statistics relative to the insane are found in the census of 1871.

In the four provinces which constituted the Dominion of Canada at that time the insane were numbered as follows: Ontario, 4081; Quebec, 3300; New Brunswick, 788; Nova Scotia, 1254. Total, 9423.

The latest official publication containing figures of the insane and defectives is the Government Census for 1911, when the insane in Canada by provinces were as follows:

Province	Number
Alberta	43
British Columbia	713
Manitoba	1156
New Brunswick	500
Nova Scotia	1011
Ontario	6175
Prince Edward Island	275
Quebec	4772
Saskatchewan	53
Yukon	2
Northwest Territories	2
Total	14702

The idiots in 1911 by provinces were as follows:

Province	Number
Alberta	91
British Columbia	96
Manitoba	190
New Brunswick	443
Nova Scotia	644
Ontario	2656
Prince Edward Island	116
Quebec	1727
Saskatchewan	113
Yukon	0
Northwest Territories	11
Total	6087

[1] From information furnished by C. A. Porteous, M. D., Montreal, Quebec.

The above figures include all the insane and idiots in the country, that is, those in institutions and those outside.

The insane and defective institutional population in Canada in 1912-1913 consisted of the following figures by provinces:

Province	Number
Alberta (1913)	287
British Columbia (1912)	822
Manitoba (1913)	1081
New Brunswick (1913)	600
Nova Scotia (1912-13)	454
Ontario (1913)	6931
Prince Edward Island (1913)	270
Quebec (1912-13)	4370
Total	14815

VIII.

THE CHINESE AND JAPANESE IN INSTITUTIONS IN BRITISH COLUMBIA BETWEEN THE YEARS 1871 AND 1913.

During the years mentioned 228 Chinese were admitted to institutions for the insane in British Columbia as follows: In 1872, 1; 1875, 2; 1876, 2; 1877, 1; 1878, 2; 1880, 4; 1881, 1; 1882, 1; 1884, 1; 1885, 4; 1886, 5; 1887, 6; 1888, 5; 1889, 9; 1890, 5; 1891, 3; 1892, 4; 1893, 2; 1894, 5; 1895, 6; 1896, 2; 1897, 4; 1898, 10; 1899, 2; 1900, 8; 1901, 4; 1902, 9; 1903, 15; 1904, 12; 1905, 10; 1906, 10; 1907, 22; 1908, 9; 1909, 15; 1910, 4; 1911, 6; 1912, 6; August, 1913, 11. Total, 228.

Japanese.—Between 1894 and 1913 54 Japanese were admitted to institutions for the insane in British Columbia as follows: 1894, 1; 1895, 1; 1900, 2; 1901, 4; 1902, 4; 1903, 4; 1904, 2; 1905, 1; 1906, 5; 1907, 4; 1908, 8; 1909, 7; 1910, 6; 1911, 4; 1912, 2. Total, 54.

IX.

DOROTHEA L. DIX AND CANADIAN INSTITUTIONS.

As has been noted in a previous chapter[1] Dorothea Lynde Dix, not content with her labors in behalf of the insane in the United States, extended her philanthropic efforts to other countries. In the year 1848 she visited St. Johns, Newfoundland, and becoming interested in the efforts then being made by Dr. Henry Hunt Stabb to induce the government of the colony to found a permanent asylum for the insane of the island, she gave a personal donation of £100 and collected other subscriptions from abroad. But she did more than make a material contribution and secure others; her enthusiasm, her determination and efforts to aid the suffering insane as well as the poor life savers of Sable Island gave a new life and purpose to the movement for better care of the insane in Newfoundland, with the result that a well-equipped hospital was opened in 1855.[2]

As far as can be learned, the only one of the British North American colonies to which Miss Dix devoted *especial* attention was Nova Scotia. On January 21, 1850, she presented to the Legislative Assembly of the province and its dependencies a memorial praying for the immediate erection of an insane hospital to provide for the rapidly increasing number of insane of all classes, for whom no provision had as yet been made by the colony. Miss Dix's arguments, proving the crying necessity for the erection of an insane hospital, were supported by a formidable array of facts and figures gathered from various sources and countries, as well as a plain recital of the then deplorable condition of the insane in Nova Scotia. This memorial is given in full in the succeeding Appendix, as being of interest in this connection, as well as showing the methods employed by Miss Dix in forcing her views and desires on a legislative assembly.

The Province of Nova Scotia bears the further honor of having had the site of its hospital selected by Miss Dix. She took an active part in determining various questions connected with the

[1] Dorothea Lynde Dix, Ch. III.

[2] American Journal of Insanity, Vol. L, p. 130.

erection of the buildings. As an added mark of her sympathy toward the movement Miss Dix gave a collection of pictures to ornament the hospital walls. The hospital was finally opened for the reception of patients on the 26th of December, 1857.[1]

A portrait of Miss Dix is in possession of the hospital as a memorial of the invaluable aid given by her to the cause of the insane of Nova Scotia.

APPENDIX.

Appendix of Journals of House of Assembly, Nova Scotia, 1850. No. 18.

MEMORIAL TO THE HONORABLE THE LEGISLATIVE ASSEMBLY OF THE PROVINCE OF NOVA SCOTIA AND ITS DEPENDENCIES.

Gentlemen: Your memorialist respectfully asks attention in your legislative capacity to a subject embracing the welfare of a numerous and fast-increasing class of your fellow-citizens who, through want of appropriate care under the access of a terrible malady, are in many instances suffering severe hardships and aggravated miseries, and who are not only in bondage to a disqualifying physical illness preventing the right use of those functions through which the mind finds expression, but in not unfrequent cases are subject to the outward bondage of cords and straps, chains and fetters; incarcerated in filthy, unventilated apartments, cold, comfortless huts and cabins, and in dreary cells and dungeons; not seldom fed and sheltered with less care than the brutes, and pariah-like, cast beyond the pale of respect, affection and sympathy.

I refer to the insane of all classes and ages, and of both sexes, numbered now by hundreds, in the Province of Nova Scotia and its dependencies.

I am aware that this subject, appealing to your humane sensibilities and your judgment, is not now for the first time presented for your consideration; that the just claims of the afflicted do not now for the first time demand legislative action and executive sanction in your country.

I have seen that so early as February, 1846, a commission designated under the authority of His Excellency, the late Lieutenant Governor, Viscount Falkland, and created in accordance with a request emanating from the House of Assembly, communicated a comprehensive and able report in favor of establishing a hospital for the relief and cure of the insane in the province, etc. And, further, it will be recollected that His Excellency, Viscount Falkland, in conformity with a resolution of the House of Assembly, resulting from facts communicated in the above named report, appointed a second commission, consisting of five competent members, viz: The Hon. Hugh Bell, John E. Fairbanks, Alexander Sawers, A. M. Uniacke,

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[1] See "History of the Nova Scotia Hospital, Halifax," in a subsequent volume.

and Charles Twining, whose duty it was made to determine the most suitable site in the province for the erection of a lunatic asylum, and for ascertaining the probable expense of founding and sustaining such an establishment, and to report the same to the House during the session next ensuing, together with approved plans and specifications.

A special report (see House Journal, Appendix No. 11, January, 1847), based upon inquiries and estimates conducted with good judgment and fidelity to the cause, was communicated to His Excellency, Sir John Harvey, and by his command transmitted to the Legislature. This document bears date January 1, 1847, but it does not appear that any measures have been seriously proposed and supported for assuring the result recommended and urged by the commission, and which was earnestly represented as of great necessity.

I find, it is true, in a volume of your acts, a series of documents bearing the date severally, January 21, 1847, and from which I ask permission to make full extracts of such passages as bear upon the subject in question. In the opening speech before the Provincial Parliament, His Excellency, Sir John Harvey, in a manner which illustrates at once his good judgment and humane disposition, calls attention to the obligation of providing suitably for the insane, as follows:

"There is another matter which has constituted to me a subject of the most painful interest in all the colonies with which I have hitherto been connected, and which presents itself to me in a no less distressing aspect in this. I allude to the absence of suitable arrangements for the reception and treatment, with a view to relief or cure, of that class of unhappy beings which I grieve to believe is *rapidly increasing in these colonies,* owing to the causes to which I have adverted, viz: the want of those means of effectual application to the disease in its incipient stages which I regard as the solemn duty of the legislature of every colony to provide for its pauper lunatics. I accordingly earnestly recommend this subject to your serious and compassionate consideration, in connection with a very able and satisfactory report, which will be laid before you, from the commissioners appointed by my predecessor in the administration, to select the best site for the proposed building."

To this concise and persuasive appeal, incredible as it may seem, the following reply stands recorded; what meaning the respondents attached to it I have in vain endeavored to conjecture:

"On the last subject of deep and painful interest which Your Excellency has been pleased to bring under our notice, we have already, as you are probably aware, deliberated, and in the future consideration we shall give this interesting subject we shall not fail to be impressed with the pertinency and force of the remarks and reasons by which Your Excellency has recommended to our regard the care of the unhappy beings subject to the fearful malady to which Your Excellency has adverted."

It appears that the subject, though of admitted importance, has been suffered to slumber; and, as time wears away, so irrecoverably wears away the intellectual capacities of the neglected insane.

The history of most of the incurable cases brought to hospitals shows that in all probability they might have been restored by timely treatment, and it is a fact capable of demonstration, not less in Europe than in America, that though the first expense of a patient under hospital treatment is greater than in an almshouse or at private charge, the ultimate expense is much less than if they are suffered to become incurable, and so remain a life-long burthen. But pardon the seeming imputation on your liberality and justice; this is not a matter of pounds and pence, for who will be found skilled to count the cost of care and cure against the value of mental health? Who, when bringing this subject home, will be ready to determine against a cause founded in the strongest moral obligations of man to man, and which presents but one course of correct action—a course which admits no compromise, no half measures, no pause, no procrastination, a course where affirmative decision is mental salvation—a course where a negative act is mental destruction! I am sensible that many uninformed persons, when the measure for establishing a provincial hospital for the insane is first suggested, may oppose the measure on the ground that the wants of the country do not at this time demand legislative interposition. It will not be a difficult and certainly not an ungrateful task to convince all such that their opinions are based in want of correct knowledge; and that inquiry and research will dissipate all their doubts and kindle a desire to assist in forwarding a work so urgent, in place of opposing obstacles to its speedy accomplishment.

Let it be understood also that in arriving at convincing facts one need not prosecute journeys distant from the seat of government, nor compass sea and land to search out the hidden retreats of distress where the hopeless and homeless maniac raves, the demented pines, the convulsed epileptic shrieks over his impending fate, and the forlorn idiot babbles in his dismal cell. Most subjects admit of high coloring or lively exaggeration with the pencil or the pen—but this, the history of insanity, none; it transcends the highest sketches of fancy, and the most vivid descriptions of a quickened imagination.

Abundant evidence exists within the precincts of the city and county of Halifax alone to convince every investigating and intelligent mind that no time should be lost in procuring for the insane the benefits of protective and remedial care. I found in a department of the Halifax poorhouse, in September last, *forty-four* insane men and women suffering under different forms of the malady which placed them in a most helpless condition. No blame attaches to the superintendent of that institution for the manifold defects of the buildings occupied by the insane, or for the more serious deficiencies in the provision for their restraint, nursing and care; but cure, restoration to the right use of the reasoning faculties (and I appeal in support of my assertion to the medical attendant and to the visitors), is here rare indeed, *if it is not* absolutely impossible. They who pass within the gloomy, desolate walls of the men's department may well be said to leave all hope behind. The age of miracles has passed we believe, and nothing short of miraculous agency could *there* heal the sickness which

eclipses the intellect, by breaking down the physical powers. Here from various quarters are gathered those whose poverty and obscurity rank them with the neglected and the forgotten.

But it is not in the Poors' Asylum alone that examples are found which show how regardless is the government of those who are justly, and by their unequalled miseries, the *wards of the state;* in retired places, in humble dwellings throughout the country, scenes have been disclosed which language would fail to describe. I appeal to many of your citizens and to members of the Honorable Legislature for illustrations in evidence of this affirmation.

In the County of Pictou alone, according to statistics faithfully collected and furnished by James B. D. Fraser, Esq., there were *forty-six* individuals who were deprived of reason, and all of whom were fit subjects for hospital care. Some of these I have seen; of others the history has reached me through authentic and reliable sources. Throughout the province, in short, I found cases incurable through long neglect, doomed to be a life-long burden to themselves through suffering, and a life-long charge either upon their friends or the public for care and maintenance.

It is a fact very well known, that many patients, whose families have enjoyed affluence, or possessed competent fortunes, have been conveyed to hospitals in the United States to receive those cares appropriate to their condition, and which would not be assured in their own country. The objections and obstacles involved in such an alternative are too obvious to need exposition.

In Prince Edward Island, near Charlottetown, I found a small establishment for the reception of the insane, but wholly destitute, through want of funds, of all the comforts and arrangements deemed requisite for advancing the cure of the patients.

In Newfoundland is the nucleus for an institution which the humanity of the citizens will nurture into a creditable curative hospital, it is believed.

In New Brunswick is a hospital in the vicinity of St. Johns, for the establishment and support of which that government has made what, under the circumstances, must be considered very liberal appropriations. This hospital, however, cannot extend its care to citizens of another province without excluding, in consequence, patients claiming care within the boundaries of New Brunswick.

The provinces of Upper and Lower Canada have, since 1843, made, annually, appropriations which are gradually extending the blessings of hospital treatment to the insane in those two provinces. A large and liberally supported institution is established near Toronto; and at Quebec, through the unwearied exertions of Drs. Morrin, Douglas, and Fremont, their infant institution is acquiring the means of improved and far-diffused influence and benefits.

Visiting the Canadas in 1843 and 1844, I found the jail at Toronto thronged with insane patients, held in detention for their own protection and the public safety. In the jail at Montreal were above 70 of the most suffering and mismanaged patients I have ever seen; in the jail at Quebec

I found about 50 in various conditions, but in every respect more judiciously and humanely cared for than in Montreal. But scattered far and wide over that vast tract of country were isolated cases, whose dreadful condition made piteous appeals for relief and protection. Many insane in the Canadas were intrusted to the care of religious communities; in the districts of Three Rivers, Montreal, and Quebec, the government paid yearly the sum of £32 10s. for the support of each patient. But it was only the most dangerous and unmanageable, as formerly in similar institutions in Europe, who were so placed. No measures, so far as I could learn on the most careful inquiry, and on the authority of the resident medical men, were ever devised or adopted for their restoration to health and reason. They are confined in separate cells, debarred all intercourse with each other or with society abroad; left to pine in dreary solitude, without recreation or employment; without fire for warmth in winter, and imperfectly defended from the cold by scanty apparel, they became maniacal or idiotic, some piercing the heavy poisonous air of their filthy cells with loud cries, rending their clothes, or uttering low, meaningless babblings of idiocy.

From time to time strong representations reached the public ear through visitors or grand juries, who presented the unfitness of these foul receptacles for the treatment of the wretched inmates. The honored name of Sir Charles Metcalfe is forever associated with the first effective measures adopted in the Canadas for ameliorating and healing the sufferings of the insane. I can never forget the indignant and humane spirit in which he received the communications I had the opportunity of making to him, personally, and in writing, nor the promptness and efficiency of his acts in procuring a remedy for the grievances which were brought to his knowledge. Many citizens throughout the provinces zealously advanced the work of reformation, joining to their labours humane sympathy with the afflicted, and enlightened sound judgment in the accomplishment of their aims.

The temporary hospital of the lower province was opened at Beauport, about two and a half miles from Quebec, in September, 1848, and there were immediately received 87 insane, who had been for years confined in the dismal cells of the jail in Montreal, the convent at Quebec, and the nunnery at Three Rivers. Most of these had been dragging out a horrible existence under such accumulated miseries as to have become irredeemably incurable. To make them comparatively comfortable was all that could be hoped for or attained. Some had been in confinement from 20 to 28 years. A little less than 300 patients have been under care since 1848. The contracts are already made for the construction of a hospital on the most improved plans; so that without excluding the old, recent cases may not be rejected.

It will readily be supposed that great interest was excited by the first removal of the insane from the cells and dungeons to the hospital at Beauport. Of those transferred from the convent, according to the words of the physicians, "one had been confined 28 years, and several upwards

of 20. During the whole of this time they had been shut into different cells, in a low, one-story building" (I shall never forget it, nor the miserable wretches moaning and shrieking in its dark, damp cells), "surrounded by a cedar fence 12 feet high." They had never been permitted to leave the building, most of them had never been allowed to leave their small cells, and they rarely saw the countenance or heard the voice of any human being beside those who brought their daily food. They were, of course, filthy in their habits, and many of them destructive in their propensities.

Much apprehension was experienced by those who had had charge of them on the morning when they were to be released. But experience here verified the predictions of the humane and enlightened. The results corresponded singularly with those which blessed the determined efforts of Pinel in France nearly half a century earlier.

They were removed in open carriages and in cabs. They offered no resistance; on the contrary, they were delighted with the ride; and the view of the city, the river, the trees, the beautiful sky, and the passers-by, excited the most pleasurable emotions. On their arrival they were placed at table at breakfast, and it was most interesting to witness their amazement and their delight. All traces of ferocity, turbulence and disorder had vanished; they found themselves again in the world, treated like rational beings, and endeavored to behave as such. One, a man of education and talents, but whose mind was in fragments, after a confinement of 26 years, wandered from window to window; knew at once familiar objects in the city, the ships, the boats on the river and bay, but could not comprehend the steamers. Before leaving the convent the nuns had caused him to be clothed; it was 19 years since he had worn shoes. Another patient, who was disposed to be restless, demanded a broom, and forthwith commenced sweeping, requiring all about him to fall into some sort of employment. As soon as their muscular powers were sufficiently restored, they were induced to adopt employments congenial with their former trades and habits. They were often conducted through the gardens and grounds.

The effect of this system was soon apparent, they became stronger, ate and slept regularly, and some of them recovered the use of their reason.

On the 28th of September 52 insane patients were received from the dungeons and cells of the Montreal jail. As a class they were more violent and destructive than the patients previously received; but having been a less period in confinement, more have in proportion been recovered. On the 8th of October seven patients arrived from Three Rivers, chained and handcuffed like a gang of galley convicts. They had for a long time been chained to the floor of their cells; they were all easily managed after a few days. Kindness and humane cares were the potent charms by which the furious were tranquilized and the curable restored.

Permit me to remind you, gentlemen of the Legislature, that in the establishment of well-managed hospitals for the insane, not only are the obligations due to humanity fitly acknowledged and cancelled, but that

through these measures political economy, no less than general social and individual benefits, is assured.

In this age, when information on all subjects of public interest and importance is so widely diffused, it is unnecessary to refer specially to the history of hospitals for the cure of the insane, or to enter into an exposition of the benefits of care for every class of these under the modern system, characterized as it is in all civilized countries by the exercise of skill and kindness on the part of all those who hold responsible places in the administration of these institutions.

It is well understood that sound physical health is the best protection against the development of insanity; whatever, therefore, assists bodily vigor in like manner promotes the healthy functions of the brain. The malady of insanity, when brought under *early efficient* treatment, is, except there be organic disease, equally manageable and curable as a fever or a cold. The mischiefs of delay in securing hospital care cannot be too strongly insisted on. Hundreds and thousands of incurable cases, within the range of my own obervation alone, attest the inhumanity and cruelty of procrastination.

Pinel, Esquirol, Falret, Jacobi, Heinroth, Connolly, Ellis, Browne, Bell, Awl, Kirkbride, Buttolph, Stribling, Douglas, Morrin, and a host beside, whose talents and experience are of almost world-wide repute, have urged, and continue to urge, this truth, and in persuasive language press upon individuals and communities the performance of their obvious duty to this most dependent class of sufferers.

Removal from all accustomed scenes and influences appears to be essential for successful treatment of the insane. Willis, the distinguished physician to George the Third, dismissed His Majesty's family, courtiers, officers and domestics, procured strangers as nurses and attendants, and thus first advanced the restoration of the distracted monarch and controlled his insane delusions. "Entirely to disconnect the insane from their accustomed intercourse with relatives and friends, associates and servants," writes M. Pinel, "is the indispensable and imperative plan for commencing a course of treatment which may promise favorable results." Falret declares that all experience demonstrates that the kind of isolation preferable to all others is alone found in establishments especially devoted to the insane. "Few," writes Halloran, "recover under any course of domestic treatment." The superintendent of one of the most successful hospitals in England, in a report issued in 1842, declared that in a large proportion of cases admitted during the year then closed, owing to a long detention by ill-judged friends amongst the sick, or by the negligence of parish officers amongst the poor, the prospects of recovery for the largest part were entirely precluded, and that in the successful cases, "*the period of treatment bore generally an accurate ratio to the prior duration of the disorder.*" The visiting commissioners of the same hospital report that they cannot too strongly express their conviction from experience, that the chances of

cure are materially lessened, and not unfrequently defeated, by the delays which are suffered to take place in sending patients to an hospital after confirmation of the malady. The physician of the Retreat in New York stated in a late report that *forty-nine* years' experience establishes the fact of recovery of four cases to one brought under care within three months of the first attack, while it is less than one to four in cases of more than twelve months' duration when admitted.

The superintendent of the fine hospital in Edinburgh states that "to be treated successfully, insanity must be treated early; ill-founded sensibility and false prejudices often operate to prevent this being done."

Not only do delays in placing patients in hospitals involve the risk of permanently establishing the malady, but the safety of property and security of life is hazarded in innumerable instances.

In a report by Dr. Stribling, to the Legislature of Virginia, I find the following record: "Of all cases received into the hospital this year, *ninety-seven* were recent; of these *eighty-three* have been restored to their accustomed health, to usefulness, and to their families; five remain in an improved condition; three unimproved; and six have died before an opportunity was had to test remedies in their behalf." "Of 158 cases remaining in the hospital at Staunton in 1845, and probably doomed to life-long insanity, I cannot question the recovery of nearly all, had they been *subject* to early and appropriate moral and medical care. In many cases the selfish and morbid sentiments of friends led them to reject hospital aid till too late to secure its first and highest *benefits,* and the best care and highest efforts of skill are unavailing. They are maniacs for life, and unhappy victims of false pride or mistaken affection on the part of their relatives.

The following table derived from a report of the Kentucky State Hospital shows the cases of less than one year's duration when admitted to that institution during a period of 14 months, noting the whole numbers cured, relieved, unimproved, and deceased, together with the per cent of cures on the admissions and discharges:

Admitted.		Recovered.	Relieved.	Unimproved.	Died.	Per cent cures to admissions.	Per cent cures to discharges.
Men......	127	94	16	8	9	74.15	91.23
Women...	73	51	13	2	7	69.86	87.93
Total....	200	145	29	10	16	72.05	90.62

"I have intimated," adds the same judicious physician, "that institutions for the right treatment of the insane are demanded, not only for their care and cure, but also on the score of economy."

The following table shows the truth of this position and the reason why it is so:

A Table Showing the Comparative Cost to the State of Twenty Old and Twenty Recent Cases of Insanity, Illustrating the Importance in an Economical Point of View of Placing Such Persons Under Treatment at an Early Period of Their Disease, and of Providing Every Means of Treating Them Successfully in an Asylum.

OLD CASES.				RECENT CASES.			
No.	Age.	Time spent in asylum.	Cost of ea. case at $51 pr. an.	No.	Duration before ad-mission.	Time spent in asylum.	Cost of ea. ease at $1.50 pr. wk.
1	47	20 years	$1,300	1	1 week	36 weeks	$54.00
2	48	20 years	1,300	2	7 weeks	16 weeks	24.00
3	52	17 years	1,105	3	3 months	32 weeks	48.00
4	54	16 years	1,140	4	2 months	40 weeks	60.00
5	47	17 years	1,005	5	2 months	20 weeks	30.00
6	46	15 years	975	6	2 months	20 weeks	30.00
7	51	14 years	910	7	3 months	12 weeks	18.00
8	31	13 years	845	8	1 month	20 weeks	30.00
9	33	11 years	715	9	2 months	28 weeks	42.00
10	45	12 years	780	10	3 months	24 weeks	36.00
11	37	10 years	650	11	6 months	24 weeks	36.00
12	39	10 years	650	12	6 months	32 weeks	48.00
13	33	12 years	780	13	4 months	28 weeks	42.00
14	45	15 years	975	14	4 months	12 weeks	18.00
15	48	16 years	1,040	15	6 months	8 weeks	12.00
16	56	12 years	780	16	1 month	8 weeks	12.00
17	44	13 years	715	17	2 months	24 weeks	36.00
18	47	15 years	975	18	1 month	20 weeks	30.00
19	36	13 years	845	19	6 months	12 weeks	18.00
20	36	9 years	580	20	1 month	20 weeks	30.00
			$18,030				$654.00

Aggregate cost of 20 old cases, $18,030.

Average time spent in asylum by each, 14 years.

Average cost of each case, $901.50.

Average cost of 20 recent cases, $654.

Average time spent in asylum, nearly five months.

Average cost of each case, $32.14.

Of 122 patients discharged from the Connecticut Hospital in 1848, 70 were recovered, 23 improved, 17 not improved, and 12 died. Since the first opening of that institution in 1824, 1897 have been recovered and restored to their friends.

Of patients discharged from the Pennsylvania Hospital, Dr. Kirkbride reports for the year 1848:

Cured	120
Much improved	23
Improved	24
Stationary	19
Died	17
Total	203

Of the patients discharged cured, 57 were residents of the hospital not exceeding three months, 35 between three and six months, 24 between six months and one year, and 4 for a longer period than a year.

Of those discharged "much improved," 9 were under treatment less than three months; 4 between three and six months; 8 between six months and one year; and 2 for more than one year.

Premature removals cannot be too earnestly deprecated. "Precipitate removals," writes Dr. Ray, of Rhode Island, "lead to disastrous, because to irremediable, and sure evils. Friends either are not aware or are not willing to admit that hospital care in the first instance is better suited for attaining recovery than home treatment; and if, finally, they yield to the urgent necessities of the case, after hazardous delays, and confide the patient to an institution adapted to his condition, they do not seem sensible that insanity is of much longer duration than most acute diseases, and that in many, if not in most, cases which finally are restored, weeks and often months pass without sensible improvement. The duration of insanity, though far more various than most diseases, is governed by a law scarcely less inflexible."

According to observations made by Esquirol during a series of years at the Salpétriere, where the stay of the patient is determined by the will of the physician, not the caprice of friends or of officials, most of the permanent recoveries were effected within one year, and most others subsequent to the close of the tenth year. The average duration of the malady was there found to be about one year.

Friends are not easily convinced that those they have loved and cherished decline under their own indulgence and watchfulness; unfortunately the evil which grows out of their ill-advised experiment upon the exquisitely delicate organization of the brain too often baffles the profoundest skill of the anxious physician to whom, as a last resort, the luckless patient is transferred.

Let it be remembered that those who would mitigate or heal human woe in its most appalling and concentrated powers must provide liberally and seasonably for the insane.

The experience of many years, writes Dr. Butler, strengthens the conviction that both humanity and sound practical economy demand of every state and country that all the insane within their respective borders should be suitably cared for, so that all recent cases shall have every possible facility for restoration, and all chronic cases shall receive every alleviation their pitiable condition admits.

"The insane," writes Dr. Chandler, "have just claims on the community for support. All persons are more or less liable to cerebral disease. Every year some of our best minds become deranged, and a retreat is sought for them in hospitals, where they are shielded from any sources of affliction, and where are found the best aids for their recovery."

"Under well directed hospital care," writes Dr. Luther V. Bell, "recovery is the rule, permanence the exception."

Dr. Brigham, the late superintendent of the New York State Hospital, failed not to reiterate in his annual reports the obligation of placing patients under appropriate treatment early after the manifestation of the malady.

Dr. Rockwell in every report to the Legislature of Vermont proves the ill consequences of delayed care.

Dr. Ellis, director of the West Riding Hospital for the Insane, stated in 1827 that of 312 patients received within three months of their first attack 216 recovered, while of 318 admitted whose malady ranged from one year to thirty less than 50 perfectly recovered.

Dr. Veitch, recently of the Salpétriere, declares that of 152 old cases, 5 only could be said to regain the sound exercise of reason.

Dr. Barrows reported 91 of 100 recent cases cured, and Dr. Willis made corresponding statements to the British public. The records of the Senavia and Milan hospitals accord with those already quoted.

I have been led to produce these various and accredited authorities, because it seems to me that a mass of evidence so unquestionable should have weight in influencing the decisions of the honorable body I address.

In the Massachusetts State Hospital in 1843 *twenty-five old cases* had cost $54,157 (about £13,539 1s. currency), the average expense of these being $2166.20. The whole expense of *twenty-five recent cases* till recovered was $1461.30; average expense of the same, $58.48, being a little more than £14 3s. currency.

In the Western Hospital, Virginia, *twenty old cases* had cost $41,633; average cost, $2081.65. The whole expense of *twenty recent cases* was $1263, the average expense of twenty recent cases till recovered, $63.23.

The cost of supporting 102 cases in different hospitals had amounted to $201,336, and on an average each had cost $1973.88, while in the same institutions the same number of recent cases discharged cured amounted to only $6068.60, or to an average of $59.49.

In one single institution in New England three cases of incurable insanity first admitted have already cost their friends $11,100, or $3700 for each; while three cases of recovery have cost $170.74, or only $56.96 each. The old cases, so far as is apparent, had they been brought under early treatment, might have been recovered and not have remained a sorrow of heart and heavy burthen upon the pecuniary resources of their friends; the last, which were recent cases, are already sharing in society the duties of citizens, and in their own families the blessings and joys of domestic affection.

In 1844-45 104 patients were discharged recovered from the Massachusetts State Hospital whose cases were *recent* at the time of their admission. At the same hospital the per cent recovery in all *recent* cases was

89½ in 1843; 79 in 1846; 72 in 1847; 86 in 1848; and of *old* cases 31½ in 1845; 28 in 1846; 17 in 1847; 19 in 1848.

In the hospital at Augusta, Me., the average time of recent cases recovered was 157 days; that of old cases recovered was 229 days.

I have endeavored to prove the advantages to be possessed by hospital care and treatment for the insane; I have tried to illustrate the disadvantages of domestic care and treatment for this suffering class of our fellow-beings. I have glanced at the inefficiency and cruelty of a *poorhouse* residence for the epileptic and the maniac. In imagination, for a short hour, place yourselves in their stead; enter the horrid, noisome cell, invest yourselves with the foul, tattered garments which scantily serve the purposes of decent protection; cast yourselves upon the loathsome pile of filthy straw; find companionship in your own cries and groans, or in the wailings and gibberings of wretches miserable like yourselves; call for help and release, for blessed words of soothing and kind offices of care, till the dull walls are weary in sending back the echo of your moans; then, if self-possession is not overwhelmed under the imaginary miseries of what are the actual distresses of the insane, return to the consciousness of your sound intellectual health, and answer if you will longer refuse or delay to make adequate appropriations for the establishment of a provincial hospital for those who are deprived of reason, and thereby of all that gladdens life or makes existence a blessing.

It may be proper to refer here to facts connected with the monetary outlays for hospitals for the insane; that these institutions, at least in the United States, once substantially built, finished and furnished, with rare exceptions, sustain themselves from the receipts from paying patients, and the poor whose actual expenses are met by the counties or parishes in which they have their residence, a few examples may strengthen this illustration.

At the State Hospital in Augusta, Me., the whole number of cases treated during 18 months ending March, 1848, was 257; of these 127 remained under treatment. Outlays, including salaries and contingent expenses, $17,-543.76; cash received by the treasurer, $16,992.70; leaving the trifling balance of $551.06 against the hospital.

The products of the farm were as follows, viz:

40 tons of hay	$8.00	$320.00
400 bushels of potatoes	.75	300.00
130 " " oats	.40	52.00
100 " " beets	.50	50.00
75 " " carrots	.25	18.75
90 " " turnips	.50	45.00
3,350 lbs. of pork	.08	268.00
8 tons of oat straw	4.00	32.00
Small vegetables, cabbages, beans, peas, green corn, apples, etc., estimated		75.00
		$1,160.75

Nothing so much gratifies the patient as a consciousness of being useful, the knowledge that his work can be turned to some good account. Sales from eight acres of ground cultivated in vegetable production at Bloomingdale Hospital afforded the last year returns of more than $4000. At another hospital of 217 patients, 130 were actively engaged in outdoor work from five to seven hours daily, 16 in spinning, 12 in knitting, 12 in washing, 18 in ironing, 16 in whitewashing and weaving, and 12 in learning to read and in spreading the tables at the hours for meals. At the Maryland Hospital 45 of 89 patients are habitually employed in useful work. Dr. Chandler reports of his patients as follows:

"Our inmates have performed as much labor the past year on the farm as usual. The garden has looked as well and has yielded as abundantly. The effects of labor on those who work are salutary, unless they overwork, which is not apt to be the case, except in certain recent cases. Physical health is promoted and mental quietude is increased by outdoor exercise, and some profitable labor is the most agreeable way of taking it. We try to furnish our inmates with as much exercise on a farm and in the garden as they can be induced to take. It has been in a few cases the great means of their recovery. This establishment has been liberally supplied during the summer with vegetables from the garden, and, besides these, that have been consumed at the time, the following lists, with their prices, are presented with the products of the farm:

110 bushels of corn	at $ .90	$ 99.00
75 " " potatoes	" .50	37.50
25 " " dry beans	" 1.25	31.25
11 " " dry peas	" 1.00	11.00
107 " " green peas	" 1.00	107.00
95 " " beets	" .34	32.50
345 " " turnips	" .25	86.25
40 " " parsnips	" .67	26.80
105 " " onions	" .67	70.35
25 " " apples	" .50	12.50
1,500 cabbages at 4 cents apiece		60.60
36,500 quarts milk at 3½ cents a quart		1186.25
4,736 pounds of beef at 6¼ cents		298.50
4,273 " " pork at 6¼ cents		267.06
90 " " poultry at 10 cents		9.00
		$2334.76

There was raised for wintering the stock:

50 tons of hay at $10 per ton	$500.00
1,206 bushels of carrots at 25 cents	301.50
Corn fodder	15.00
	$816.50

"Female patients occupy time in various kinds of needle-work, in reading, exercise, and also household employments, according to their previous

habits and the nature and state of their disease. The male patients have a variety of occupations in the shops, on the grounds, in the reading-room and in exercise halls. No restraints are imposed which can be dispensed with; no peremptory word is uttered when persuasion will avail; the law of the hospital is the law of kindness, and the spirit which prevails is the spirit of good-will."

The report of the New Hampshire State Hospital for 1848-49 shows:

Outlays	$11,829.95
Receipts	12,132.89

leaving a balance in favor of the hospital.

Whole number of patients under treatment during the year	190
Remaining	114

"The hospital farm, it is well known, was a few years since but little more than a barren waste. Seven years since it yielded but from three to four tons of poor hay; the present year the same lands have produced 35 tons. The crop of potatoes was 1000 bushels; corn, 315 bushels; rye, 100 bushels; and a proportionate amount of other crops. The next year we look for more abundant returns for our improvements and labor."

The report of the Vermont State Hospital at Brattleboro for 1848 shows:

Outlays	$30,995.93
Receipts for board of patients	31,295.34

"The farm has afforded good return for labor expended. Every institution should have sufficient land to furnish the patients with abundant employment in its cultivation. All agricultural and horticultural pursuits, rightly directed, have a salutary effect. But the great benefit resulting from manual labor connected with an hospital for the insane cannot be reckoned in dollars and cents. Its advantages can only be justly estimated *as one of the most efficient means* for the restoration of the curable, and for the cheerfulness, enjoyment and comfort of the incurable. Every facility should be furnished to patients of both sexes for beneficial employment and pastime."

The official report of the Connecticut Hospital for the Insane (Retreat) at Hartford exhibits for the year ending April, 1849:

Expenditures	$24,582.99
The receipts nearly balance the account, being	24,272.84
Number of patients in the course of the year	255
Number remaining	133

"We avail ourselves," adds Dr. Butler, "of all suitable varieties of occupation, exercises and amusements of every form of which we can have control, as appliances for the improvement of the patients. Excursions also, visits to objects of interest, rides, walks, games, musical and dancing parties, sewing circles, quiet and social meetings, etc., all are sought in order to vary the monotony of hospital life."

The first report of the Rhode Island Hospital, after having been opened for but 13 months, shows an expense table nearly balanced by its income, the deficiency but $593.

"Our farm," writes Dr. Ray, "has every quality desirable for such an establishment—a dry and productive soil, beautiful groves, and agreeable prospects. The grounds consist of 115 acres, nearly equally divided into cultivated soil and native woodland, furnishing the means of exercise and recreation. By the class of patients accustomed to labor, employment is readily embraced."

I might proceed to furnish extracts from many reports in addition to the authorities already quoted, but it seems unnecessary to multiply these attested facts, or to advance new arguments as motives for the performance of a high and noble duty of unquestionable obligation. Economy comes in aid of all humane influences and impulses to assist your favorable and prompt legislation in favor of the insane classes in Nova Scotia.

The Board of Commissioners in their report in 1847, having dwelt at length on the plan and manner, in their judgment, best adapted for the construction of an edifice suitable for all hospital purposes, and also having offered their views respecting the choice of a suitable farm and site for the same, it remains only for me to add briefly a few suggestions on these points:

First. I recommend without reservation the plan of construction adopted in the State of New Jersey for the hospital which that state has recently finished and opened for the insane.

Second. I urge that a farm of not less than 150 acres of arable land, and 50 or 100 acres of woodland, be secured for the use of the hospital, either in the vicinity of Halifax or of Truro. A good farm is indispensable; and not less is an ample supply of pure free-stone water, which shall be derived from unfailing sources. Another consideration on which I lay great stress is the choice of a cheerful situation for the hospital buildings; in such proximity also to a large city or port town as to afford easy communication, not only for ease in obtaining supplies for the use of the institution, but for convenient intercourse of the officers and nurses of the same, it being obvious that at not unfrequent periods they should have opportunity of changing painful for more cheerful scenes, to maintain their own proper mental balance and health.

The physician should be a married man, and, with his family, reside in the hospital, and devote to its interests his whole time and energies. The institution should be established on such a basis as to receive all classes of patients, and on no consideration be ranked as a pauper institution. It is time that people should have learnt that to be insane is not to be disgraced; that sickness is not to be ranked with crime; and that mental disability is almost invariably the result of mere bodily ailments.

"There is a cure for these in patience and kind care." The triumph of thought and humane influences over disease, so manifest in the results daily witnessed in our well-ordered hospitals for the insane, is rapidly conquering false pride and false opinion. Minds are no longer to be sacrificed to the selfish and narrow sensibilities and ideas of friends and kindred—

"One lost mind whose star is quenched
Has lessons for mankind."

And man is daily learning his duty through these solemnly inculcated instructions.

I have not, I do not, gentlemen of the Legislature of Nova Scotia, solicit you to engage in a work of questionable importance—one which may or may not assure good results. You have the experience of all modern civilized nations to assist your judgment, and quicken the promptings of your hearts to righteous legislation. The age of experiment has passed—the age of facts is in the present. The question then is, not whether you will appropriate funds for a hospital, hoping good may thence ensue, but whether you will venture, as responsible citizens and just legislators, to *refuse* what you *know* will heal the sick and restore those whose reason is shattered through physical maladies, and whose only hope of restoration is through your correct appreciation of their miserable condition, and their true claims on the state for such succor as is alone availing.

Shall Nova Scotia be last and least in responding to the loud calls of humanity—shall she be latest and alone in affording evidence of Godliness, civilization, and the improvements and great moral works which characterize the present age?

Your memorialist believes otherwise, and in the confidence this belief inspires respectfully submits this cause to the Honorable Assembly to which she addresses this appeal. D. L. Dix.

From Montgomery, Alabama, and forwarded to Halifax from Washington, D. C., United States of America, December 10, A. D. 1849.